Evidence for change of birth date of deceased is shown on

FILM No. I 00 JAN 11 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11820

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. Horn Point
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Eliza Atkinson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Harry Atkinson
6.(c) If alive, give age 1855 years
7. Birth date of deceased (mo., day, yr.) May 20 1865

8. AGE: Years	Months	Days	If less than one day
90	7	7	hrs. min.

8. Birthplace England (town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace
MOTHER 14. Maiden name Unknown
15. Birthplace
18. Informant Mrs Tom G. Taylor
Address Horn Pt. Eastport Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec 28 1945 (month) (day) (year)
Cemetery or crematory
Location New Bedford Mass
18. Funeral director John M. Taylor & Son
Address Annapolis Md
19. Dec 28, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1945, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov - 1 1945, to Dec 27 1945
and that I last saw h[illegible]R alive on 12-27 1945

Immediate cause of death	DURATION
acute Coronary Thrombosis	
Disease	
Due to	
Due to	
Other conditions Left Ventricular Failure	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Eastport Md Date signed 12-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

11821

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No. 108 Cathedral (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Frances Viola Buck

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widow

6.(b) Name of husband or wife: Harry Buck

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Jan 19 - 1889

8. AGE: Years: 56 Months: 11 Days: 6 If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: Joseph Tucker; 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Nancy Polley; 15. Birthplace: Maryland

18. Informant: Emma Root

Address: 108 Cathedral St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 26/45 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md

18. Funeral director: A. L. Hopkins

Address: Annapolis Md

19. Dec. 26 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 23 1945, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13th 1945, to Dec 23 1945

and that I last saw h.. alive on Dec 23 1945

Immediate cause of death	DURATION
Pulmonary TB	Several yrs.
Due to: Ca. Myocarditis	Several yrs.
Due to: Acute Cardio Vascular Failure	Few Days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Elias Lucas M. D. or other

Address: Annapolis Md Date signed 12/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

11822

Reg. Dist. No. 21

1. PLACE OF DEATH:

County a a

City or town Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years

Hospital, institution, or street address where death occurred:

406 Adams

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 406 Adams

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret Elizabeth Beavin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 29 1906

8. AGE: Years 39 Months 5 Days 21 If less than one day ..... hrs. ..... min.

9. Birthplace Annapolis. Md (Town, county, and state)

10. Usual occupation School teacher

11. Industry or business

FATHER 12. Name Everett E Beavin

FATHER 13. Birthplace Annapolis. Md

MOTHER 14. Maiden name Minnie Scott

MOTHER 15. Birthplace Prince Geo Co

16. Informant Minnie Beavin

Address 406 Adams St Eastport. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 22/45 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis. Md

18. Funeral director B. L. Hopkins

Address Annapolis. Md

19. Dec. 21 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28, 1944 to Dec. 20 1945

and that I last saw h alive on Dec 15 1945

Immediate cause of death	DURATION
Fibroid Anaemia; General carcinomatosis	1 1/2 yrs.
Due to Carcinoma of colon	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. J. Klawans, MD M. D. or other

Address 31 South East ave Date signed 12/20/45

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

11823½ 1

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Weems Creek - Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Weems Creek
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Henry Berry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Anne Berry

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 12, 1848

8. AGE: Years	Months	Days	If less than one day
97	5	13	hrs. min.

9. Birthplace: Rutland, Vermont
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: —

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: George Henry Berry
Address: Weems Creek, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 28. 1945 (month) (day) (year)

Cemetery or crematory: Weems Creek Cemetery

Location: near Annapolis, Md.

18. Funeral director: John M. Taylor and Son

Address: Annapolis, Maryland

19. (Date rec'd by registrar) 19 Wm French Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25 1945, at 10p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1944, to Dec 25 1945 and that I last saw h... alive on Dec 23 1945

Immediate cause of death	DURATION
Myocarditis & Myocardial Insufficiency	Several Years
Due to	
Due to	
Other conditions Cerebral Sclerosis	Years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo C Boyd M. D. or other

Address Annapolis Md Date signed 12-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

11824

Reg. Dist. No. 23

1. PLACE OF DEATH:
County Anne Arundel
City or town Patapsco Park
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
P.O. Address: Brooklyn, RDRoute 9
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Patapsco Park Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. P.O. Address, Brooklyn, RDR 9
(If rural give LOCATION) 25
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME ISAAC BOOZE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife xxxx Elanora Henson
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1st January 1883

8. AGE: Years	Months	Days	If less than one day
62	11	20	____ hrs. ____ min.

9. Birthplace Calvert County Maryland
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name John Booze
13. Birthplace Maryland
MOTHER 14. Maiden name Eliza
15. Birthplace Maryland
16. Informant Mrs. Rosetta B. Lindsay
Address Box 490 Brooklyn, 25, Md RDR
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 25 '45 (month) (day) (year)
Cemetery or crematory Mount Calvary
Location
18. Funeral director Mrs. Katie R. Williams
Address 322 North Schroder St. Balitmore
19. 23 Dec 1945 (Date rec'd by registrar) CALDWELL WOODRUFF MD (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1945 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 18 1945 to Dec 20 1945, and that I last saw h im alive on Dec 20 1945

Immediate cause of death Chronic Myocarditis — DURATION
Duration About 5 months?
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John W. Gaines, M.D. or other
Address 507 W. Hamburg St. Date signed 12/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11825

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Texas County: Travis

City or town: Austin (If outside city or town limits, write RURAL and give nearest town)

Street No. 4520 Avenue B (If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Mary F. Boyd

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: John W. Boyd

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Feb 13 - 1890

8. AGE: Years	Months	Days	If less than one day
23	10	17	..... hrs. ..... min.

9. Birthplace: Princeton W. Va (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business

FATHER — 12. Name: Tim Winemiller

13. Birthplace: West Va

MOTHER — 14. Maiden name: Josie Elliott

15. Birthplace: Tiptop Va

16. Informant: Tim Winemiller

Address: West Gate A. A. Co. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 2 1946 (month) (day) (year)

Cemetery or crematory: Wells Sons

Location: Weems Creek

18. Funeral director: B. L. Hopkins

Address: Annapolis Md

19. Date rec'd by registrar: Jan 2, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30 1945 at 9:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 27 1945, to Dec. 30 1945

and that I last saw her alive on Dec. 30 1945

Immediate cause of death	DURATION
Pneumonia Gastric Hemorrhage	2 days
Due to: Undetermined Cause	
Due to:	
Due to:	
Other conditions: Congenital Lues.	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Bowers M.D. (M. D. or other)

Address: Annapolis Md Date signed 1/1/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11826

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years, 2 months, 5 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital.

How long in hospital or institution? 6 years, 2 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1116 E. Pratt Street.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME James Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	married

6.(b) Name of husband or wife: Daisy Brown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1899

8. AGE: Years: 46 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: South Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER

12. Name: Albert Brown

13. Birthplace: South Carolina

MOTHER

14. Maiden name: Fannie McCray

15. Birthplace: South Carolina

16. Informant: Hospital Records

Address: Crownsville Maryland

17. Burial, cremation, or removal: Burial Date thereof: Dec. 21 45 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Cemetery

Location: Baltimore Md

18. Funeral director: Elroy O. Wilson

Address: 1009 E. Brantley

19. 12-18-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15 1945 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10, 1939 to December 15 1945

and that I last saw h— alive on December 15 1945

	DURATION
Immediate cause of death: General Paresis	6 years to its onset
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Neal V. Anderson M. D. or other

Address: Crownsville Md Date signed: 12-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30.6

CERTIFICATE OF DEATH

11827

Reg. Dist. No. 18

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months, 22 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 10 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: St. Inigoes
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

3.(a) FULL NAME: BUTLER - LILY MAE

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: ———
6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): 1901

8. AGE: Years	Months	Days	If less than one day
44	unknown		——— hrs. ——— min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business: ———

FATHER
12. Name: Frank Butler
13. Birthplace: Maryland

MOTHER
14. Maiden name: Eliza Johns
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 13, 1945 (month) (day) (year)
Cemetery or crematory: St. Peter's
Location: Ridge, Maryland

18. Funeral director: P. B. Robinson
Address: Leonardtown, Maryland

19. 12/12/45 (Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9, 1945, at 11:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 17, 1945, to Dec. 9, 1945
and that I last saw her alive on December 9, 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 2/13/45
Due to: ———	
Due to: ———	
Other conditions: ———	

(Include pregnancy within 3 months of death)

Major findings of operations: ——— Date of op.: ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of: ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ———
Means of injury: ——— Injured at work? ———

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 12/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 11828

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 26 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 3 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)
Street No. 2103 McCulloh Street (If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: CAMPHOR - JAMES

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married (?)

6.(b) Name of husband or wife: Helen Camphor, 2103 McCulloh St., Balto., Md. 6.(c) If alive, give age: unk. years (?)

7. Birth date of deceased (mo., day, yr.): 1891

8. AGE:	Years	Months	Days	If less than one day
	54	unknown		--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Clara ?
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec. 15, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore City
18. Funeral director: Archibald A. Gaddis
Address: 2101 McCulloh St., Baltimore, Md.

19. Dec 13 1945 E.T. Joyce Local Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12 19 45 at 2:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 16 19 45 to Dec. 12 19 45 and that I last saw him alive on December 12 19 45

Immediate cause of death: General Paresis — DURATION: Known to us since 8/24/45
Due to: ------
Due to: ------
Other conditions: ------
(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op. ------
Autopsy results: ------
PHYSICIAN: Please underlioe the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of ------
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ------
Means of injury ------ Injured at work? ------

23. SIGNATURE: Albert V. Armstrong M. D. or other
Address: Crownsville, Maryland Date signed: 12/12/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-a)

CERTIFICATE OF DEATH

11829 P

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Severn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 2901 - Parkwood Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Delma May Caplow

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married.

6.(b) Name of husband ~~or wife~~ Julius Caplow
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) January 26 - 1916

8. AGE: Years	Months	Days	If less than one day
29	10	14	..... hrs. ..... min.

9. Birthplace Severn, Maryland. (Town, county, and state)
10. Usual occupation Housewife.
11. Industry or business
FATHER 12. Name George T. Duvall
FATHER 13. Birthplace Annearundel Co. Md.
MOTHER 14. Maiden name Laura Phelps
MOTHER 15. Birthplace Severn, Md.
16. Informant Julius Caplow (husband)
Address 2901 - Parkwood Ave. Baltimore, Md.
17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 12/13/45 (month) (day) (year)
Cemetery ~~or crematory~~ Friendship
Location A. A. Co. Md.
18. Funeral director William Cook Inc.
Address 1217 St. Paul St.
19. 12/12 19 45 B. L. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 1945, at 3:15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1945 to 12/10/45 1945
and that I last saw h~~e/she~~ alive on 12/10/45 1945

Immediate cause of death	DURATION
Heart failure	2 days
Due to General asthenia	
Due to Carcinoma of cervix	18 months
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations = Carcinoma of cervix - by Dr. Brady. Date of op. Aug - 1945
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide NO Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave H. Bachert M.D. M. D. or other
Address Glen Burnie, Md. Date signed 12/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

11830

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town on the Severn River.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town New Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #3 - Box 822

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Anna Dora Carlson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife John Victor Carlson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 4th 1858

8. AGE:	Years	Months	Days	If less than one day
	87	3	26	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation none

11. Industry or business

MOTHER FATHER

12. Name John Dressell

13. Birthplace Germany

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant George E. Carlson

Address R.F.D. #3 - Box 822 Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 4th 1945 (month) (day) (year)

Cemetery or crematory Family Plot.

Location New Annapolis Md.

18. Funeral director John W. Taylor & Son

Address Annapolis Md.

19. Dec. 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1945, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 24 1945, to Dec 1 1945

and that I last saw h... alive on Nov 30 1945

Immediate cause of death	DURATION
Myocarditis Chr	Several Yrs
Myocardial Insufficiency	
Due to	
Due to	
Other conditions Arteriosclerosis	Many

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George E. Carlson M. D. or other

Address Annapolis Md. Date signed 12-2-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

11831

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1. PLACE OF DEATH:

County: A. A.

City or town: Crownsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: A. A.

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. General Highway
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Edith May Carr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh.	Married

6.(b) Name of husband ~~or wife~~: James A Carr

6.(c) If alive, give age: 85 years

7. Birth date of deceased (mo., day, yr.): August 21, 1874

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
71	3	16	—	—

9. Birthplace: Anne Arundel County, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER — 12. Name: Jessie Trott

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: —

16. Informant: Gladys A. Malinofsky (Daughter)

Address: 2508 Brohawn Ave, Balto.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 11/45 (month) (day) (year)

Cemetery or crematory: London Park

Location: Balto Md

18. Funeral director: D L Hopkins

Address: Annapolis, Md.

19. Dec 10 1945 (Date rec'd by registrar) 27 Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 7, 1945, at 10.15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2, 1945, to Dec. 7 1945 and that I last saw her alive on December 6, 1945

Immediate cause of death	DURATION
Coronary Thrombosis	5 days
Due to: Chronic Myocarditis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State): —

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address: Crownsville, Md. Date signed: 12-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11832

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 78 years
Hospital, institution, or street address where death occurred: 57 Calvert St. Annapolis Md.
How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 57 Calvert St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Joseph Silas Carroll

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Married

6.(b) Name of husband or wife: Rose Carroll
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): January 4, 18 67

8. AGE: Years	Months	Days	If less than one day
78	11	5	____ hrs. ____ min.

9. Birthplace: Parole Md. (Town, county, and state)
10. Usual occupation: Waiter
11. Industry or business: None

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Charles Carroll and Florence Carroll
Address: 57 Calvert St. Annapolis Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12 / 16 / 45 (mooth) (day) (year)
Cemetery or crematory: Brew Hill Cemetery
Location: West St. Extd.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 North west St. Annapolis Md.

19. Dec. 14 19 45 (Date rec'd by registrar) ____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/10 19 45 at 9.25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2, 19 45 to Dec 10 19 45
and that I last saw h~~im~~ alive on Dec 10, 19 45

Immediate cause of death	DURATION
Cardiac Failure	4 days
Due to Mitral Constriction	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: H. W. Johnson M. D.
M. D. or other
Address: 80 Northwest Street Date signed: 12/13/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

11833

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Severn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A A

City or town: Severn

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Florence Clark

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband ~~or wife~~: Josiah Clark

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 2, 1873

8. AGE: Years	Months	Days	If less than one day
72	10	8	..... hrs. ..... min.

9. Birthplace: Prince George County (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Edward Disney

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Margaret Winkley

MOTHER — 15. Birthplace: Md.

18. Informant: Mr. Josiah Clark

Address: Severn Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/12/45 (month) (day) (year)

Cemetery or crematory: Friendship A. A. Co.

Location: Severn

18. Funeral director: Wm. J. Tickner & Sons Inc.

Address: North & Pa. Aves. Baltimore

19. 12/11/45 (Date rec'd by registrar) D. W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 10-45 19..... at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 8-45 19.. to Dec 10-45 19..

and that I last saw her alive on Dec 8-45 19..

Immediate cause of death	DURATION
Acute Cardiac Failure	2 days
Due to	
Due to	
Other conditions: Carbuncle Extremities	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address ..... Date signed 12-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2008)

CERTIFICATE OF DEATH

★ 11834

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Johnston Town, P.O. Pasadena, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months.
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: A-A.
City or town: Johnston, P.O. Pasadena.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joan Priscilla Cornish.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	B.	Single.

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug - 2 - 1945

8. AGE:

Years	Months	Days	If less than one day
0	4	24	..... hrs. ..... min.

9. Birthplace: Johnston Town, A-A. County.
(Town, county, and state)

10. Usual occupation: None.

11. Industry or business

FATHER — 12. Name: Elijah A. Cornish.
13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Priscilla Murstock.
15. Birthplace: Johnston Town, A-A. County.

16. Informant: Elijah A. Cornish (Father)
Address: Johnston Town, A-A. County.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-28-45 (month) (day) (year)
Cemetery or crematory: Maryolly
Location: A-A Co.

18. Funeral director: Josiah Brown
Address: Balto., Md.

19. 12-26 19 45 (Date rec'd by registrar) J. A. B. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26 19 45 at 7:20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Baby found dead in bed at about 7:20 A.M. - no	
Due to asymptomatic epilepsy with status epilepticus	
Due to accidental. No violence.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gustave H. Faucher M.D. M. D. or other
Address: Glen Burnie, Md. Date signed 12/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11835

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 165 Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Richard Eldridge Crosby

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah E. Crosby
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): April 20 1878

8. AGE: Years: 67 | Months: 8 | Days: 1 | If less than one day: ... hrs. ... min.

9. Birthplace: A. A. Co. Md. (Town, county, and state)
10. Usual occupation: Fireman at U. S. Naval
11. Industry or business: Academy Annapolis Md.
FATHER 12. Name: Richard Crosby
13. Birthplace: A A Co Md.
MOTHER 14. Maiden name: Sarah Moreland
15. Birthplace: A A Co Md.
16. Informant: Sarah E. Crosby
Address: 165 Main St. Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 23 1945 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.
18. Funeral director: John M. Taylor & Son
Address: Annapolis Md.
19. Dec. 23 1945 (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 21 1945 at 5:25 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11 1945 to Dec 21 1945
and that I last saw him alive on Dec 20 1945

Immediate cause of death	DURATION
Cardio Vascular Failure	Sudden
Due to Cr. Myocarditis	about 3 yrs.
Due to Bronchiectasis	several yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: J. Oliver Purvis M. D. or other
Address: Annapolis Md. Date signed: 12/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

CUTHBERTSON

11836

Reg. Dist. No. 71

1. PLACE OF DEATH:
County Anne Arundel Co
City or town Mountain Rd. Lake Shore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Lake Shore
(If outside city or town limits, write RURAL and give nearest town)
Street No. Mountain Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bet Cuthbertson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Rosa
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 19. 1893

8. AGE: Years	Months	Days	If less than one day
52	5	0	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Watts Cuthbertson
13. Birthplace: N. C.
MOTHER 14. Maiden name: Cuthbertson
15. Birthplace: "
16. Informant: Mrs. Rosa Cuthbertson
Address: Lake Shore, A.A. Co, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec. 21 1945 (month) (day) (year)
Cemetery or crematory: Salisbury, N. C.
Location: Salisbury N. C.
18. Funeral director: William A. Jackson
Address: 916 Penna, Ave. Balto
19. 12/21/45 Accepted (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 19 1945, at 8 30 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 17th 1945 to Dec 19th 1945
and that I last saw him alive on Dec 19th 1945

Immediate cause of death	DURATION
(a) Due to: Lobar Pneumonia	5 days
(b) Due to:	
Other conditions: Chronic Endocarditis, Chronic Duct. Nephritis, Uremia (Include pregnancy within 3 months of death)	Unknown

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John L. Alexander M. D. or other
Address: Glen Burnie Md Date signed 12/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

11837

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Winchester Station
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Winchester Station
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Thomas H. Davis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Carrie S. Davis
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar 24th 1870

8. AGE:

Years	Months	Days	If less than one day
75	8	22	..... hrs. ..... min.

9. Birthplace: A A Co Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: William Davis
13. Birthplace: A A Co Md.
MOTHER 14. Maiden name: Mollie Purdy
15. Birthplace: A A Co Md.
16. Informant: Carrie S. Davis
Address: R. F. D. Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 19th 1945 (month) (day) (year)
Cemetery or crematory: Asbury
Location: Arnolds Md.
18. Funeral director: John M. Taylor & Son
Address: Annapolis Md.
19. Dec 19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 15 1945 at 11:30 P. M.
21. I CERTIFY that death occurred on the date above stated. ~~That I attended deceased from 19.. to 19..~~ and that I last saw ~~him alive on~~ Dec 16 1945
Post mortem Examination

Immediate cause of death	DURATION
Acute Dilatation of Heart	Sudden
Due to: Chronic Myocarditis	unknown
Due to: Arteria-Sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John M. Taffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed 12-15-45

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (109)

CERTIFICATE OF DEATH

11838

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel.

City or town: Severna Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Jones

(If outside city or town limits, write RURAL and give nearest town)

Street No.: old highway at school rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Jerome Day

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	S.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 9. 1945

8. AGE: Years: — | Months: 2 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Jones - A.A. Md. (Town, county, and state)

10. Usual occupation: Infant.

11. Industry or business

FATHER — 12. Name: Charles Johnson

13. Birthplace: Md.

MOTHER — 14. Maiden name: Hazel Day

15. Birthplace: Md.

16. Informant: Mother

Address: Jones - Md.

17. Burial (Burial, cremation, or removal. Which?): Burial Date thereof (month) (day) (year): Dec 26 1945

Cemetery or crematory: Mt Calvary

Location: Arnold

18. Funeral director: J. B. Johnson

Address:

19. Dec 26 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-24 19 45 at 2 before 25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-24 19 45 to 12-24 19 45 and that I last saw h alive on seen after death 19

Immediate cause of death	DURATION
Congestion of lungs	few minutes
Due to suffocation or aspiration (?)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Congested lungs & petechial hemorrhages

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. Peabody Jewett M.D. (M. D. or other)

Address: 17 x Green St Date signed: 12-24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11839

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A A

City or town Defence Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Defence Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie May Drury

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27th 1865

8. AGE: Years 79 | Months 11 | Days 20 | If less than one day ... hrs. ... min.

9. Birthplace A A Co Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Daniel Collins

13. Birthplace A A Co Md.

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs Edwin Shylock

Address 245 Hanover St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 20th 1945 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis Md.

18. Funeral director John W. Taylor & Son

Address Annapolis Md.

19. Dec 20 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1945, at 6.25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1942, to Dec 16 1945 and that I last saw h.e.r. alive on Dec 16 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Cerebral Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Lin Leavitt M. D. or other

Address Chesapeake Md. Date signed 12-14-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

11840

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos 5 days
Hospital, Institution, or street address where death occurred:
Crownsville, State Hospital, Md
How long in hospital or institution? 3 mos 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Charles Co.
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ernest Duckett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Widower

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
72	—	—	...hrs. ...min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Farm Laborer

11. Industry or business —

FATHER 12. Name

FATHER 13. Birthplace

MOTHER 14. Maiden name unknown

MOTHER 15. Birthplace

16. Informant Hospital Records

Address Crownsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/26/45 (month) (day) (year)

Cemetery or crematory Bruce Chapel

Location La Plata, Md. (Rural)

18. Funeral director Hewitt & Ryon

Address Waldorf, Md.

19. 12/27/45 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1945, at 1:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 17, 1945 to Dec. 22, 1945 and that I last saw him alive on December 22, 1945

Immediate cause of death	DURATION
General Arteriosclerosis	Known to me since Sept 17, 45
Due to	
Due to	Known to me since Sept 17, 45
Other conditions Senile Psychosis	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE Ward V. Brinsfield M. D. or other

Address — Date signed 12-22-45

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11841

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town St Margarets
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Alice A. Duvall

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Weems R. Duvall
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28th 1886

8. AGE: Years	Months	Days	If less than one day
59	11		hrs. min.

9. Birthplace Baltimore Co Md.
(Town, county, and state)
10. Usual occupation Home wife
11. Industry or business
FATHER 12. Name Robert H. Chapman
13. Birthplace Maryland
MOTHER 14. Maiden name Belinda Hayes
15. Birthplace Maryland
16. Informant Weems R. Duvall
Address St Margarets A.A.Co Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jany 3rd 1946 (month) (day) (year)
Cemetery or crematory St Margarets Cemetery
Location St Margarets A.A.Co Md.
18. Funeral director John W. Taylor & Son
Address Annapolis Md.
19. Jan. 3 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31st 1945 at 1309 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1936 to Dec 31 1945 and that I last saw her alive on Dec 31 1945

Immediate cause of death	DURATION
Cor. Lymph. Tuberculosis	9 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C Beard M. D. or other
Address Annapolis Md Date signed 1-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11842

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: a. a.

City or town: Potapsco Pk. Baltimore Co

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: a e.

City or town: Potapsco Pk. Balto. 25

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Zeppelin Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Nancy Dyson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widow

6.(b) Name of husband or wife: Henry Dyson

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec. 1 - 1867

8. AGE: Years: 78 | Months: | Days: 27 | If less than one day: hrs. min.

9. Birthplace: ? (Town, county, and state)

10. Usual occupation: None.

11. Industry or business:

FATHER — 12. Name: Levi Thompson

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Eliza Stokley

15. Birthplace: Maryland

16. Informant: Mrs. Arda Revelle

Address: Zeppline Ave (Patapsco Pk.)

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-31-45 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore Md.

18. Funeral director: William G. Jackson

Address: 916 Penna. Ave. Balto Md

19. 12/29/45 (Date rec'd by registrar) D.E. Reland Registrar

D.H.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 28 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26 1945, to Dec. 28 1945

and that I last saw h.. alive on Dec. 28 1945

Immediate cause of death: Cardio-Vascular Disease — DURATION: 24 yr.

Due to:

Due to:

Other conditions: Grippe — 1 week

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas. L. Bale M.D. M. D. or other

Address: Linthicum Date signed: 12-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of birth date of deceased is shown on 2411 N. Charles St., Baltimore 930

11843

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FILM No. 106 JUL 31 1946

Reg. Dist. No. 25

1. PLACE OF DEATH:
County ANNE ARUNDEL
City or town BROOKLYN HEIGHTS-25 (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 WEEKS
Hospital, institution, or street address where death occurred:
4900 Brannon Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State PENNA. County LANCASTER
City or town LANCASTER (If outside city or town limits, write RURAL and give nearest town)
Street No. 556 S. DUKE ST. (If rural, give LOCATION)
2.(a) If veteran, name war V

3.(a) FULL NAME BELLE MARTIN EAVENSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife REESE EAVENSON
7. Birth date of deceased (mo., day, yr.) JULY 26 1874 (1871) 6.(c) If alive, give age 71 years

8. AGE:

Years	Months	Days	If less than one day
74	4	27	....hrs. ....min.

9. Birthplace PENNA. (Town, county, and state)
10. Usual occupation HOUSE WIFE
11. Industry or business HOUSE KEEPING
FATHER 12. Name ELIJAH MARTIN
13. Birthplace PENNA.
MOTHER 14. Maiden name MARY THOMPSON
15. Birthplace PENNA
16. Informant James R. Eavenson
Address 27 Liberty Pkwy Plumbolk
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 12/28/45 (month) (day) (year)
Cemetery or crematory OLD SADSBURY FRIENDS
Location CHRISTIANA, PA.
18. Funeral director L. E. Tyson
Address Riding Sun, Md.
19. Dec 23 1945 Ida M. Whitson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1945 at 12:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 23 1945 and that I last saw h.. alive on Dec 22 1945

	DURATION
Immediate cause of death: coronary occlusion	
Due to: hypertensive cardiovascular disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide.... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury Injured at work?

23. SIGNATURE P. W. Kuster M.D. M. D. or other
Address 302 Patapsco Ave Date signed 12/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

11844

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 304

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mo., 8 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 6 mo., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Brandywine
(If outside city or town limits, write RURAL and give nearest town)
Street No. ----
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: EDELEN - BERNARD J.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

6.(b) Name of husband or wife: Maggie Edelen
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): ---- 1882

8. AGE: Years	Months	Days	If less than one day
63			....hrs. ....min.

9. Birthplace: Maryland -- Brandywine
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: ----

FATHER
12. Name: John Edelen
13. Birthplace: Maryland

MOTHER
14. Maiden name: Nancy ?
15. Birthplace: Maryland

16. Informant: Hospital records
Address: Crownsville, Maryland

17. Burial, cremation, or removal. Which?: Burial — Date thereof: 1/2 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville

18. Funeral director: Hutt Hospital
Address: Crownsville

19. (Date rec'd by registrar) 1/2 19 46 — E T Joyce — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23 1945, at 7 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1945, to December 23 1945 and that I last saw him alive on December 23 1945.

	DURATION
Immediate cause of death: General Paresis	known to us
Due to:	June 15, 1945
Due to:	
Other conditions: ----	

(Include pregnancy within 3 months of death)

Major findings of operations: ----
Date of op.:
Autopsy results: ---- ----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of: ----
Where did injury occur? ---- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----
Means of injury: ---- Injured at work? ----

23. SIGNATURE: Hutt & Pinkerton M. D. or other
Address: Crownsville, Maryland Date signed: 12/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11845

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Marley Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Marley Park (Glen Burnie P.O.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Thomas R. Ellingsworth

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 11, 1880

8. AGE: Years	Months	Days	If less than one day
65	1	9	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Candy maker (retired)

11. Industry or business: Self

FATHER 12. Name: William Ellingsworth

FATHER 13. Birthplace: Baltimore

MOTHER 14. Maiden name: Elizabeth Adams

MOTHER 15. Birthplace: Baltimore, Md.

16. Informant: James M. Taylor

Address: Marley Park (Glen Burnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 22,45 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. Dec 22 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20 1945 at 3.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Heart failure	
Due to Hypertension	
Due to Right hemiplegia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Gustave H. Faubert M.D. M. D. or other

Address: Glen Burnie Md. Date signed: 12/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

11846

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs.
Hospital, Institution, or street address where death occurred:
Odenton Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rachel Sophia Faidell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife: Wm. H. Faidell
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept 21 - 1867

8. AGE: Years: 78 | Months: 3 | Days: — | If less than one day: — hrs. — min.

9. Birthplace: Brooklyn Md.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: Bucy Mallonee
13. Birthplace: Brooklyn Md.

MOTHER
14. Maiden name: Henrietta Lewis
15. Birthplace: A. A. Co.

16. Informant: Harry Faidell
Address: Odenton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 23/45 (month) (day) (year)
Cemetery or crematory: Bethel Cemetery
Location: Ft Meade Md
18. Funeral director: The H. C. White Co Inc
Address: Laurel Md

19. Dec 23 1945 (Date rec'd by registrar) Elara Hardesty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 21st 1945 at 10 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 1st 1943 to Dec. 21st 1945
and that I last saw h[illegible] alive on Dec 7th 1945

Immediate cause of death	DURATION
a. Myocardial Insuff.	2 days
Due to: Hypertensive - Cardio - Vascular Disease	2 yrs
Due to: Hypertension	2 yrs. ±
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank Shipley M. D.
M. D. or other
Address: Savage Md. Date signed 12/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11847

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 11 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 4 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)
Street No.: 214 North Durham Street (If rural, give LOCATION)
2.(a) If veteran, name war: ------ ✓

3.(a) FULL NAME: FEASTER - WILLIE

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	divorced

6.(b) Name of husband or wife: ------
6.(c) If alive, give age: ----- years
7. Birth date of deceased (mo., day, yr.): 1902

8. AGE: Years	Months	Days	If less than one day
43	unknown		---- hrs. ---- min.

9. Birthplace: South Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: ----

FATHER
12. Name: Morris Feaster
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Fanny ?
15. Birthplace: South Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 19, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Anne Arundel County

18. Funeral director: Leroy O. Wilson
Address: 1000 Brantley Avenue, Balto., Md.

19. Dec 15 19 45 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 19 45 at 7:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 3 19 45 to Dec. 14 19 45 and that I last saw him alive on December 14 19 45

Immediate cause of death	DURATION
General Paresis	Known to us since 8/14/45
Due to: -------	
Due to: -------	
Other conditions: -------	

(Include pregnancy within 3 months of death)

Major findings of operations: ---------
Date of op.: -----
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: -----
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ---------- Injured at work? -------

23. SIGNATURE: Lloyd V. Hubbard M. D. or other
Address: Crownsville, Maryland Date signed: 12/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2d

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 Southgate Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emma Buch Feldmeyer

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: George J. Feldmeyer
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Nov 28th 1865

8. AGE: Years: 80 | Months: 1 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Harrisburg Pa
(Town, county, and state)
10. Usual occupation: none
11. Industry or business
FATHER 12. Name: William Buch
13. Birthplace: Penn
MOTHER 14. Maiden name: Emma C. Weaver
15. Birthplace: Phila Pa
16. Informant: George J. Feldmeyer
Address: 2 Southgate Ave Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 27th 1945 (month) (day) (year)
Cemetery or crematory: St Annes
Location: Annapolis Md.
18. Funeral director: John M. Taylor & Son
Address: Annapolis Md.
19. Dec. 23 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 22 1945, at 9 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1945, to Dec 22 1945
and that I last saw her alive on Dec 21 1945

	DURATION
Immediate cause of death: Myocarditis & Myocardial Lumping	2 Years
Due to:	
Due to:	
Other conditions: Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C. Boyle M. D. or other
Address: Annapolis Md. Date signed 12.23.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-a)

CERTIFICATE OF DEATH

11849

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Millersville, Md. R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Millersville, Md. R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Crain Highway (Benfield)

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John Feuerhardt

3.(b) Social Security Number: 216-05-2772

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Auguste J. Feuerhardt

eeFreiherr

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): October 25 1874

8. AGE: Years	Months	Days	If less than one day
71	1	21	...hrs. ...min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Eastern Box Co., Balto. Md.

FATHER — 12. Name: Carl Feuerhardt

FATHER — 13. Birthplace: Litau Poland

MOTHER — 14. Maiden name: Marie Meuchling

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs. John Feuerhardt

Address: Millersville Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 19, 1945 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Brooklyn Md. R.F.D. 7

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. Dec 18 1945 (Date rec'd by registrar) Mrs. E. Allen Davis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1945, at 12.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1- 1945 to 12/16/45 1945

and that I last saw h~~im~~ alive on 12/15/45 1945

Immediate cause of death	DURATION
Acute heart dilatation	2 week
Due to: Chronic interstitial nephritis	3 mth
Due to: Senility.	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Gustave A. Poucher M.D. M. D. or other

Address: Glen Burnie, Md. Date signed: 12/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

12894

★ Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Rural Pasadena, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Iowa County:
City or town: Nevada
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: Worad War II ★ ✓

3.(a) FULL NAME: FINK, Ray Herman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Angie Fink
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 14, 1921

8. AGE:	Years	Months	Days	If less than one day
	21			hrs. min.

9. Birthplace: (Electrician)
(Town, county, and state)
10. Usual occupation: Electrician
11. Industry or business:

FATHER
12. Name: Herman Fink
13. Birthplace: Garwin, Iowa

MOTHER
14. Maiden name: Mary Reen Fink
15. Birthplace: Gladbrook, Iowa

16. Informant: Lt. C. W. Lipscomb USCGR
Address: Capt. of Port, Baltimore, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 25 February 1946 (month) (day) (year)
Cemetery or crematory:
Location: Nevada, Iowa
18. Funeral director: Walters Funeral Home
Address: Pratt & Stricker Streets, Baltimore, Md.

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 December 1945 19 at about 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~and that I last attended deceased from~~ Postmortem Examination 19 Feby. 23 19 46 and that I last saw deceased on ~~or about~~

Immediate cause of death	DURATION
Drowning	
Due to: Accidental	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Dec. 1, 1945
Where did injury occur? Chesapeake Bay, Near Sevenfoot Knoll Light Station (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Chesapeake Bay
Means of injury: drowning Injured at work? Yes

23. SIGNATURE: John M Caffey M.D. Deputy Medical Examiner M. D. Examiner
Address: Annapolis Md Date signed: 2/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11850 28

Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)
Street No.: 1615 McElderry Street (If rnral, give LOCATION)
2.(a) If veteran, name war: --------

3.(a) FULL NAME: FOSTER - LOTTIE (Lottie Scott)

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1906

8. AGE:

Years	Months	Days	If less than one day
39	unknown		---hrs. ---min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: -------

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 6, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cemetery
Location: Anne Arundel County

18. Funeral director: Mrs. Robert Elliott
Address: 1129 N. Caroline St., Balto., Md.

19. 12/3/45 (Date rec'd by registrar) E. Thayer Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1 1945 at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17 1945 to Dec. 1 1945 and that I last saw her alive on December 1 1945

	DURATION
Immediate cause of death: Schizophrenic Exhaustion	Known to us since 11/17/45
Due to: Schizophrenia	
Due to: -------	
Other conditions: -------	

(Include pregnancy within 3 months of death)

Major findings of operations: -------
Date of op.: -----
Autopsy results: ---------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: -----
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: --------- Injured at work? ------

23. SIGNATURE: Robert V. Strickroot M. D. or other
Address: Crownsville, Maryland Date signed: 12/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

Reg. Dist. No. 21 — 1182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Ac A. Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 41 Larkin St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Green, Joyce Ann.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 23, 1944

8. AGE: Years: 1 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Annapolis (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Buisco White

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Elizabeth Green

15. Birthplace: Baltimore

16. Informant: Rosie Scatty

Address: 41 Larkin St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 27, 1945 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis

18. Funeral director: J. B. Johnson

Address: Annapolis Md

19. Dec 27 1945 (Date rec'd by registrar)

Registrar: D. Brown

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/23 1945, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12/22 1945, to 12/23 1945

and that I last saw h... alive on 12/23 1945

	DURATION
Immediate cause of death: 2 or 3 hours —	36 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: burns — Date of 12/23/45

Where did injury occur? Annapolis (City or town) Aa. (County) Md. (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: fire in home — Injured at work?

23. SIGNATURE: S. Bornstein MD (M. D. or other)

Address: Annapolis Md — Date signed: 12/26/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

CERTIFICATE OF DEATH

11852

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 98 College Creek Terrace Annapolis Md.
How long in hospital or institution? *********************

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Annapolis Md. (If outside city or town limits, write RURAL and give nearest town)
Street No. 98 College Creek Terrace (If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Mollie Green
3. (b) Social Security Number: None

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Thomas Henry Green
6.(c) If alive, give age: **** years
7. Birth date of deceased (mo., day, yr.): July 20, 1889

8. AGE:

Years	Months	Days	If less than one day
56	6	18	......hrs. ......min.

9. Birthplace: Annapolis Md. A. A. Co. (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business: None

FATHER
12. Name: Issaac Franklin
13. Birthplace: Calvert Co.

MOTHER
14. Maiden name: Ella Gray
15. Birthplace: Waterbury Md. A. A. Co.

16. Informant: Miss Henreitta Green
Address: 98 College Creek Terrace

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 12 / 23/45 (month) (day) (year)
Cemetery or crematory: Brew Hill Cemetery
Location: West St. Extd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Dec. 21 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19, 1945, at ...... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15, 1944, to Dec 19, 1945, and that I last saw h er alive on Dec 19, 1945

	DURATION
Immediate cause of death: Diabetic Coma	1 day.
Due to: Diabetes Mellitus	4 years
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: ...... Date of op. ......
Autopsy results: ......

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ...... Date of ......
Where did injury occur? ...... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ......
Means of injury ...... Injured at work? ......

23. SIGNATURE: [signature] M. D. or other
Address: Annapolis, Md. Date signed 12/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 11853 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 8 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 month, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3. (a) FULL NAME: GREGORY - ROBERT

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widower

B.(b) Name of husband or wife: ------
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): June 12, 1866

8. AGE:	Years	Months	Days	If less than one day
	79	5	21	---- hrs. ---- min.

9. Birthplace: North Carolina
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: ----

FATHER
12. Name: William Gregory
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Caroline ?
15. Birthplace: North Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/10-45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville
18. Funeral director: Supt. of Hospital
Address: Crownsville

19. Dec 10 1945 (Date rec'd by registrar) Joyce Lee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3 1945 at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 26 1945 to Dec. 3 1945 and that I last saw him alive on December 3 1945

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 10/26/45
Due to: ----------	
Due to: ----------	
Other conditions: Psychosis With Cerebral Arteriosclerosis	Known to us since 10/26/45

(Include pregnancy within 3 months of death)

Major findings of operations: -------
Date of op.: ----
Autopsy results: -------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: -------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ----------
Means of injury: ---------- Injured at work? ----

23. SIGNATURE: Herbert V. Armstrong M. D. or other
Address: Crownsville, Maryland Date signed: 12/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11854

Reg. Dist. No. 26

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yr. 1 mo. 27 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 5 yr. 1mo. 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 527 Burgundy Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: GROSS - TEENEY

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	black	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): ---

8. AGE: Years	Months	Days	If less than one day
50	--	--	... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: ---

11. Industry or business: ---

FATHER
12. Name: Lester Gross Pree
13. Birthplace: ---

MOTHER
14. Maiden name: Gussie Pree
15. Birthplace: - - - - -

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24, 1945 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Mount Auburn

18. Funeral director: Ernest Pree
Address: 527 Gundrey Street

19. 12/21 1945 D. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20 1945, at 2 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 23 1939, to December 20 1945 and that I last saw him alive on December 20 1945

Immediate cause of death	DURATION
General Paresis	Known to us since Nov. 18, 1939
Due to:	
Due to:	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: --- Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work?

23. SIGNATURE: Robert J. Brothers M. D. or other

Address: Crownsville, Maryland Date signed: Dec. 20, '45

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

CROWNSVILLE STATE HOSPITAL
CROWNSVILLE, MD.

DR. ROBERT P. WINTERODE, SUPT.

TELEPHONE, SOUTH SHORE 2751

December 21, 1945

TO WHOM IT MAY CONCERN:

Teeney Gross was admitted to this Hospital on October 23, 1939, and we have no proof of his age.

Yours very truly,

Robert P. Winterode, M.D.
Superintendent

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

11855

Reg. Dist. No. 2

1. PLACE OF DEATH: A.A.

County.....

City or town.....Severn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md.....County.....

City or town.....Severn

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME Max Gubert

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Amelia M. Porcher nee Maennes 6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) April 6, 1890

8. AGE: Years	Months	Days	If less than one day
55	8	9	.....hrs. .....min.

8. Birthplace Germany

(Town, county, and state)

10. Usual occupation Brass Moulder

11. Industry or business Bth. Shp Bldg Co

FATHER 12. Name —

13. Birthplace —

MOTHER 14. Maiden name —

15. Birthplace —

16. Informant Mrs Amelia Gubert

Address Severn Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/19/45 (month) (day) (year)

Cemetery or crematory Western

Location Baltimore, Md

18. Funeral director Harry A. Wentzel

Address 4101 Edmondson Ave

19. 12/18/45 19..... Cuttenden

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 19 45 at .....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 19 45 to Dec 15 19 45

and that I last saw b.m. alive on Dec 14 19 45

Immediate cause of death	DURATION
Carcinoma of respiratory organs	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE O B Wheeler M.D.

M. D. or other

Address 1279 Millard N Date signed 12/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Whittle
1279 William St

11856

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Diat. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Cumberstone
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Cumberstone
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sue Wilcox Cheston Hacker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Morris Hacker
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 14th 1870

8. AGE:

Years	Months	Days	If less than one day
75	1	28	hrs. min.

9. Birthplace: West River A A Co Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Galloway Cheston
13. Birthplace: A A Co Md

MOTHER
14. Maiden name: Elizabeth Galston
15. Birthplace: A A Co Md

16. Informant: Miss Susan C Hacker
Address: Cumberstone A A Co Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 14th 1945 (month) (day) (year)
Cemetery or crematory: Christ Church A A Co Md
Location: Owensville Md.

18. Funeral director: John W Taylor & Son
Address: Annapolis Md.

19. 12/14/45 (Date rec'd by registrar) H. R. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12 19 45, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 12 1945 to December 16 1945 and that I last saw h. alive on December 11 1945

Immediate cause of death	DURATION
coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D.
M. D. or other
Address: Lothian, Md. Date signed: 12/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for addition of information in red is shown on FILM No. I 00 FEB 19 1946

12891

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 20.

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Edgewater P.O., Woodland Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred: None.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Woodland Beach, Edgewater P.O.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Clara Josephine Harris

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W.

6.(b) Name of husband or wife: George Harris

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 8, 1868

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
76	10			

9. Birthplace: ~~Unknown~~ Washington, D.C.

(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business: Own home.

FATHER — 12. Name: ~~Unknown~~ John Fitzgibbons

FATHER — 13. Birthplace: High Seas

MOTHER — 14. Maiden name: ~~Unknown~~

MOTHER — 15. Birthplace

16. Informant: Miss Catherine Harris

Address: 3233 M St. N.W., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 22, 1945 (month) (day) (year)

Cemetery or crematory: Holy Rood Cemetery

Location: Washington, D.C.

18. Funeral director: W W Chambers Co.

Address: 3072 - M St. N.W.

19. Dec. 20, 1945 19.... (Date rec'd by registrar) C Hunter. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20 1945, at 9.10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 27 1945, to Dec 20 1945

and that I last saw h... alive on Dec 16 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	11/23/45
Due to: Generalized arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. F. Klawans MD (M. D. or other)

Address: 31 South gate Rd Date signed: 12/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

11857

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, Institution, or street address where death occurred:
Parole Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Parole Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: James Wessley Harris

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Carrie Elizabeth Harris
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): March 10 1872

8. AGE:	Years	Months	Days	If less than one day
	73	9		...hrs. ...min.

9. Birthplace: Lothian Md. A. A. Co. (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: None

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Miss Edna Harris
Address: Parole Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/3/46 (month) (day) (year)
Cemetery or crematory: Asbury Cemetery
Location: Smithville Rd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Jan 2 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30, 1945 at 3:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June, 1944 to Dec 30, 1945 and that I last saw h... alive on Dec. 30, 1945

Immediate cause of death	Cerebral Apoplexy	DURATION 2 days
Due to	Arterial Hypertension	2 years
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. L. Rushworth M.D. M. D. or other
Address: Annapolis Md. Date signed 1/3/46.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

11858

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (103)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 52 Pleasant st
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 52 Pleasant st
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas Haste. | 3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	single

B.(b) Name of husband or wife

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 17 1934

8. AGE: Years	Months	Days	If less than one day
11	10		hrs. ..... min.

9. Birthplace Annapolis (Town, county, and state)
10. Usual occupation School boy
11. Industry or business

FATHER
12. Name Eugene Hasty
13. Birthplace Annapolis

MOTHER
14. Maiden name Mary Mc. Neal
15. Birthplace Annapolis

16. Informant Viola Horney
Address 52 Pleasant

17. Burial (Burial, cremation, or removal, Which?) Date thereof Jan. 2 1946 (month) (day) (year)
Cemetery or crematory Brewer Hill
Location Annapolis
18. Funeral director J. B. Johnson
Address Annapolis

19. Jan. 2 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29, 1945 at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated: [redacted] Post mortem Examination [redacted] Dec. 30 1945

Immediate cause of death	DURATION
Lobar Pneumonia	5 days
Acute Pleurisy	5 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Coffey M.D. M. D. or other
Address Annapolis, Md. Date signed 1/1/46

Deputy refused Examination

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B3E)

CERTIFICATE OF DEATH

11859

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Galesville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Galesville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Elizabeth Hicks

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col	Widow

6.(b) Name of husband ~~or wife~~: Alexander Hicks
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1, 1888

8. AGE: Years	Months	Days	If less than one day
57	9	13	hrs. min.

9. Birthplace: (Town, county, and state)
10. Usual occupation: House work
11. Industry or business
FATHER 12. Name: UNKNOWN
13. Birthplace
MOTHER 14. Maiden name: UNKNOWN
15. Birthplace
16. Informant: Margaret Bowers
Address: Galesville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 17 (month) (day) 1945
Cemetery or crematory: Samuel Stanton Mem
Location: West River, Md
18. Funeral director: D. C. Stockbridge Son
Address: Galesville Md
19. Dec 16 1945 J. B. Dent. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 1945, at 2 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 29 1945 to Dec 14 1945 and that I last saw h.. alive on Dec 11 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	15 days
Due to	
Due to	
Other conditions: Gen'l Debility	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F B West M. D. or other
Address: Lothian Md Date signed 12/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11856

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs., 11 mo.

Hospital, Institution, or street address where death occurred:
CROWNSVILLE STATE HOSPITAL

How long in hospital or institution? 4 yrs., 11 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1026 Stockton Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3.(a) FULL NAME: HOLT - JOHN H.

3.(b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	Widowed

6.(b) Name of husband or wife: ------

6.(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): ------ 1870

8. AGE: Years	Months	Days	If less than one day
m 75	--	---	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: ------

11. Industry or business: ------

FATHER
12. Name: William Holt
13. Birthplace: ------

MOTHER
14. Maiden name: Mary Butler
15. Birthplace: ------

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-9-46 (month) (day) (year)
Cemetery or crematory: Hollydale
Location: Crownsville Md

18. Funeral director: Supt.
Address: Crownsville

19. Jan 7 1946 (Date rec'd by registrar) E. J. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29 1945 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 29 1940 to December 29 1945 and that I last saw him alive on December 29 1945

Immediate cause of death	DURATION
Chronic Myocarditis	Known
Tuberculosis of lungs.	to us
Due to	since
	1/29/40
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op. ------

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ------

Means of injury ------ Injured at work?

23. SIGNATURE: Hart J. Hinterodt M. D. or other

Address: Crownsville, Maryland Date signed 12/30/45

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (165)

CERTIFICATE OF DEATH

11861

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: a a
City or town: annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, institution, or street address where death occurred: 149 Prince Geo St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: maryland County: a a
City or town: annapolis (If outside city or town limits, write RURAL and give nearest town)
Street No. 149 Prince Geo (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Karen Ellen Hyatt
3.(b) Social Security Number:

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Oct 29 – 1945

8. AGE: Years: Months: 1 Days: 19 If less than one day ... hrs. ... min.

9. Birthplace: Balto md (Town, county, and state)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: David Hyatt
13. Birthplace: annapolis md

MOTHER
14. Maiden name: Shirley Cohen
15. Birthplace: Balto md

16. Informant: David Hyatt
Address: 149 Prince Geo St annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 19 '45 (month) (day) (year)
Cemetery or crematory: Adas Israel Cem
Location: Baltimore – md
18. Funeral director: Jack Lewis Inc
Address: 2100 Eutaw St Balto md

19. Dec 19 1945 (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 18 1945, at 3[20] P M

21. I CERTIFY that death occurred on the date above stated; Postmortem Examination 19 ... Dec 18 1945

Immediate cause of death	DURATION
Infanticide	
Due to: by lysol	
Due to: and carbonic monoxide gas	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Homicide Date of: 12-18-45
Where did injury occur? Annapolis, A.A. Maryland (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) at home
Means of injury: lysol & carbon monoxide Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner — M. D. or other
Address: Annapolis, Md. Date signed: 12-19-45

I

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-D)

11862

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: a a

City or town: annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

149 Prince Geo St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: maryland County: a a

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 149 Prince Geo

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Shirley Hyatt

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	w	married

6.(b) Name of husband or wife: David Hyatt

6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): march 4 1919

8. AGE:

Years	Months	Days	If less than one day
26	9	14	hrs. min.

9. Birthplace: Balto md

(Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business

FATHER — 12. Name: Harry Cohen

13. Birthplace: Russia

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Russia

16. Informant: David Hyatt

Address: 149 Prince Geo St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 19/45 (month) (day) (year)

Cemetery or crematory: Adas Israel Cem.

Location: Baltimore md.

18. Funeral director: Jack Lewis Inc

Address: 2100 Eutaw St Baltimore md.

19. Dec 19 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 18 1945 at 3 25 P. M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post Mortem Examination

~~and that I last saw h~~ alive on Dec. 18 1945

Immediate cause of death	DURATION
Due to: Suicide	
Due to: Gas Carbon Monoxide Gas	
Other conditions: and Lysol	

(Incinde pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Suicide Date 12-18-45

Where did injury occur? Annapolis (City or town) A.A. (County) Maryland (State)

Injured at home, farm, industry, public place (where?) home

Means of injury: Carbon Monoxide Gas Injured at work? Lysol

23. SIGNATURE: John M. Caffy M.D. Deputy Medical Examiner M. D. or other

Address: Annapolis Date signed: 12-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

11863

CERTIFICATE OF DEATH

Reg. Diat. No. 29

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 1 mo., 17 da.

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Queen Anne's County

City or town: Centerville
(If outside city or town limits, write RURAL and give nearest town)

Street No. ------
(If rural, give LOCATION)

2.(a) If veteran, name war ----------

3. (a) FULL NAME: HYNSON - MELFORD

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	black	Single

6.(b) Name of husband or wife ------

6.(c) If alive, give age ---

7. Birth date of deceased (mo., day, yr.) ----- Unknown

8. AGE: Years 36 | Months ---- | Days --- | If less than one day ..... hrs. ..... min.

9. Birthplace: Queen Anne's County (Town, county, and state)

10. Usual occupation: None

11. Industry or business -----

FATHER 12. Name ---- Henry Hynson

FATHER 13. Birthplace Queen Anne Co

MOTHER 14. Maiden name --Mary Blake

MOTHER 15. Birthplace Queen Anne Co

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof Dec. 23, 1945 (month) (day) (year)

Cemetery or crematory: Church Hill Cemetery

Location: Church Hill, Maryland

18. Funeral director: Edgar L. Lane
Address: Church Hill, Maryland

19. 12/28 - 45 (Date rec'd by registrar) Registrar: Elsie Joyce Lowe

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 21 19 45, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 3 19 44 to December 21 19 45 and that I last saw him alive on December 21 19 45

Immediate cause of death: Lung Tuberculosis — DURATION: known to us since 10/1/45

Due to:

Due to:

Other conditions: Congenital Idiot

(Include pregnancy within 3 months of death)

Major findings of operations: -----

Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ---------- Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----------

Means of injury ---------- Injured at work?

23. SIGNATURE: Albert V. Sanders M. D. or other

Address: Crownsville, Maryland Date signed: 12/21/45

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

E. Fletcher Joyce
Millville
Md

RECEIVED
JAN 2 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (306)

CERTIFICATE OF DEATH

11864

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years, 4 months, 16 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 5 years, 4 months, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 814 Vincent Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: INGRAM (STEWART) - MARY

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: James Langston (?)
#20301 Drawer N Newark, N.J. 6.(c) If alive, give age: unk. years
7. Birth date of deceased (mo., day, yr.): 1898

8. AGE: Years: 47 | Months: unknown | Days: | If less than one day: ---hrs. ---min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ------

FATHER
12. Name: James R. Williams
13. Birthplace: Maryland

MOTHER
14. Maiden name: Laura Brown
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 14, 1945 (month) (day) (year)
Cemetery or crematory: Western Star
Location: Baltimore County

18. Funeral director: Geo. G. Kelson
Address: 1303 Presstman St., Baltimore, Md.

19. Dec 11 45 (Date rec'd by registrar) Registrar: E. F. Joyce, Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9 1945, 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 1940, to Dec. 9 1945 and that I last saw h..er alive on December 9 1945

Immediate cause of death: General Paresis — DURATION: Known to us since 7/23/40
Due to: ------
Due to: ------
Other conditions: ------
(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op. -----
Autopsy results: ------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of -----
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ------
Means of injury ------ Injured at work? ------

23. SIGNATURE: Karl S. Winstrock, M. D. or other
Address: Crownsville, Maryland Date signed: 12/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

11865

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs., 6 mo.

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 6yrs., 6 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's Co.

City or town: Largo
(If outside city or town limits, write RURAL and give nearest town)

Street No. ———
(If rural, give LOCATION)

2.(a) If veteran, name war: ———

3.(a) FULL NAME

JEFFERSON - ELIZABETH

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Single

6.(b) Name of husband or wife: ———

6.(c) If alive, give age ..... years

7. Birth data of deceased (mo., day, yr.): 1914

8. AGE: Years	Months	Days	If less than one day
31	---	---	——— hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: ———

FATHER
12. Name: Russell Jefferson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rosie Jones
15. Birthplace: Maryland

16. Informant: Hospital records
Address: Crownsvilee, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-31-45 (month) (day) (year)

Cemetery or crematory: mt Hope

Location: Calvert co

16. Funeral director: P E Duvall

Address: Prince Frederick Md

19. 12/29/45 (Date rec'd by registrar) 19 E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29 19 45 at 1:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I atteaded deceased from June 30 19 39 to December 29 19 45 and that I last saw her alive on December 29 19 45

Immediate cause of death	DURATION
Pulmanary Tuberculosis	Known to us about 1 month
Due to:	
Due to:	
Other conditions: Mental deficiency with Psychosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ———

Date of op.

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed 12/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

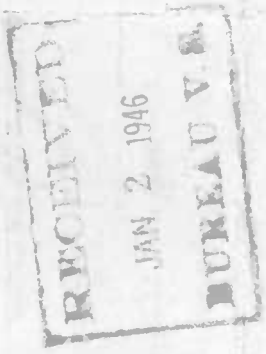
6443

Jefferson- Elizabeth

PRINCE GEORGE'S COUNTY

Admitted- June 30, 1939

Died- December 29, 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

11866

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs, 8 mos, 16 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 9 yrs, 8 mos, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: ---
City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)
Street No. 641 Pierce Street (If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: JOHNSON - GERTRUDE

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: James Johnson, 641 Pierce St., Baltimore, Maryland 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1910

8. AGE: Years: 35 Months: unknown Days: If less than one day: --- hrs. --- min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ---

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Lucie Boyd
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 12-22-45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville, Md.
18. Funeral director: Supt. Hospital
Address: Crownsville

19. 12/22/45 (Date rec'd by registrar) E. Joyce Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30 1945, to Dec. 16 1945 and that I last saw her alive on December 16 1945

Immediate cause of death: General Paresis — DURATION: Known to us since 3/30/36
Due to: ---
Due to: ---
Other conditions: ---
(Include pregnancy within 3 months of death)

Major findings of operation: --- Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? (City or town) (County) (State): ---
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Hazel V. Winters M. D. or other
Address: Crownsville, Maryland Date signed: 12/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11867

CERTIFICATE OF DEATH

★Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Regional Hospital, Ft. George G. Meade, Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County:
City or town: North Vill , Penna.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ERSTINE M. KLEMP

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			..... hrs. ..... min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U. S. Army

FATHER
12. Name: Cecil Klemp
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant:
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 28 December 45 (month) (day) (year)

Cemetery or crematory: Tuttle Funeral Home

Location: Halstead, Pennsylvania

18. Funeral director: Howard N. Blight, Jr.
Address: 4914 Belair Road

19. 28 December 1945 (Date rec'd by registrar) Frank J. Tollison, Capt., MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 December 1945, at 1610 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 December 1945, to 27 December 1945 and that I last saw him alive on 27 December 1945

Immediate cause of death	DURATION
Adrenal hemorrhages	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None performed — Date of op.:

Autopsy results: Purpuric exanthem, multiple hemorr-*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Erstine M. Klemp M. D. or other
Address: Ft. G. Meade, Md. Date signed: 28 Dec 45

* bases of small intestines, bilateral adrenal hemorrhages

MARYLAND STATE DEPARTMENT OF HEALTH

11868

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: a a

City or town: annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day 11 hours

Hospital, institution, or street address where death occurred:
17 Combell St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 Combell
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Roberta O. Lamb

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	w	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 6 - 1945

8. AGE: Years | Months | Days: 1 | If less than one day: 11 hrs. ..... min.

9. Birthplace: annapolis md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Oliver P Lamb
13. Birthplace: annapolis md

MOTHER
14. Maiden name: Harriett Clarke Powell
15. Birthplace: North Carolina

16. Informant: Oliver P Lamb
Address: 17 Combell St annapolis md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 8/45 (month) (day) (year)

Cemetery or crematory: Edwards Chapel

Location: Parole - md

18. Funeral director: D. L. Hopping

Address: annapolis. md

19. Dec 8 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 7 19 45, at 4.00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 - 6 19 45 to 12 - 7 19 45 and that I last saw her alive on 12-6 19 45

Immediate cause of death	DURATION
cerebral hemorrhage of the	6
Due to: midcervical 3 lbs	
birthweight	
Due to: fully developed	
9 mo pregnancy	
Other conditions: mother in poor	
gen. cond.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Edith Roeller M. D.
M. D. or other

Address: 42 State Circle Annapolis Date signed: 12-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11870

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? A week

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Ann Arunde

City or town: Skidmore, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Alfred H. Lloyd

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Rosie Lloyd

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 28, 1907

8. AGE: Years	Months	Days	If less than one day
38	8	8	..... hrs. ..... min.

9. Birthplace: Skidmore, A.A.Co. Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: George Lloyd

FATHER 13. Birthplace: Md.

MOTHER 14. Maiden name: Ardella Harris

MOTHER 15. Birthplace: Md.

16. Informant: Rosie Lloyd
Address: Skidmore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 23, 1945 (month) (day) (year)

Cemetery or crematory: Broadneck, [illegible]
Location: Skidmore, Md.

18. Funeral director: J.B.Johnsin.
Address: Annapolis, Md.

19. Dec. 21 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 20 1945, at 7.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 1945, to Dec 20, 1945 and that I last saw h[illegible] alive on Dec 20 1945

Immediate cause of death	DURATION
Atypical (Virus) Pneumonia	9 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M. J. Klamann M.D.
M. D. or other

Address: 31 Southgate Ave Date signed: 12/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

11869

Reg. Dist. No. 26

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 29 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 2 months, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 504 Davis Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Elijah Luttrell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	married

6.(b) Name of husband or wife: Edna Luttrell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1880?

8. AGE: Years: 65? Months: Days: If less than one day: hrs. min.

9. Birthplace: Tennessee
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Charles Luttrell

13. Birthplace:

MOTHER — 14. Maiden name: Unknown

15. Birthplace:

16. Informant: Hospital Records

Address: Crownsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 4, 1946 (month) (day) (year)

Cemetery or crematory: Mt Calvary Cem.

Location: Annapolis Road

18. Funeral director: Mrs Virgie Pinegold

Address: 1463 N. Carey St.

19. 1/2 1946 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29 1945 at 11:38 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1, 1945 to December 29 1945 and that I last saw h[illegible] alive on December 29 1945

Immediate cause of death	DURATION
Generalized arteriosclerosis	Unknown
Due to:	Long
	Once adm
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis.	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Herbert J. Thorkelson M. D. or other

Address: Crownsville Date signed: 12-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11871 21
Reg. Dist. No.

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. Chase Home, Maryland Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Janie Garner Hance Lyles

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1852

8. AGE:

Years	Months	Days	If less than one day
93	4	28	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name Thomas C. Hance
13. Birthplace Maryland

MOTHER
14. Maiden name unknown Mary E. Garner
15. Birthplace unknown Maryland

16. Informant Miss Ethel Bond
Address 86 State Circle, Annapolis

17. Burial Date thereof Dec. 21, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Christ Church yard
Location Prince Frederick, Md.

18. Funeral director John W. Taylor & Son
Address Annapolis, Md.

19. Dec. 21 1945
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19, 1945, at 1215 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 1945, to Dec 19 1945 and that I last saw her alive on Dec 19 1945

Immediate cause of death	DURATION
Bronchopneumonia	1 day
Due to	
Due to	
Other conditions Senility	

(Incinda pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert S. G. Welch M.D.
M. D. or other
Address 86 State Circle Annapolis Md. Date signed 12/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

11872

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Galesville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Galesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Lee Makell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Mar 30. 1904

8. AGE: Years	Months	Days	If less than one day
41	7	23	... hrs. ... min.

9. Birthplace: Galesville Md (Town, county, and state)
10. Usual occupation: Fish dealer
11. Industry or business

FATHER
12. Name: James Makell
13. Birthplace: Galesville Md.

MOTHER
14. Maiden name: Mary Davis
15. Birthplace: Galesville Md

16. Informant: Christine White
Address: Nash. Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 16. 1945 (month) (day) (year)
Cemetery or cemetery: Galesville Cem.
Location: Galesville Md

18. Funeral director: T. A. Standish & Son
Address: Galesville Md

19. Dec 16 1945 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 13 1945 at 1 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19.45 to Dec. 13, 1945 and that I last saw h... alive on Dec 13, 1945

Immediate cause of death	DURATION
Coronary occlusion	1/2 hrs.
Due to: Chronic Myocarditis	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: R. L. Richardson M. D. or other
Address: Annapolis Md. Date signed 12/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 11873-28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Crownsville md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years, 3 months, 24 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 2 years, 3 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester County
City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. ? (If rural, give LOCATION)
(a) If veteran, name war

3. (a) FULL NAME Mason, Myrtle

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Unknown

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1912 ?

8. AGE: Years	Months	Days	If less than one day
33 ?			..... hrs. ..... min.

9. Birthplace: (Town, county, and state) Unknown
10. Usual occupation: Unknown
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Hospital Records
Address Crownsville md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof JAN 4 1946 (month) (day) (year)
Cemetery or crematory old St. Paul Cem.
Location Shelton md. RFD

18. Funeral director: H. Harvey Bradshaw
Address Crisfield Md.

19. Jan. 4 1946 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1945 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 6, 1943 to December 30, 1945
and that I last saw her alive on December 30, 1945

Immediate cause of death: General Paresis — DURATION: Known To nursing October 3, 1943

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Hal V. Smith Evans M. D. or other
Address Crownsville md Date signed 12-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

11874

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: R.F.D. Edgewater
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1106 West St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Slater Egbert McCullough **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife: Isabelle McCullough
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 26, 1879

8. AGE: Years	Months	Days	If less than one day
66	11	13	hrs. min.

9. Birthplace: Baltimore Co. Md. (Town, county, and state)
10. Usual occupation: upholsterer & decorator
11. Industry or business:
FATHER 12. Name: Richard S. McCullough
13. Birthplace: Maryland
MOTHER 14. Maiden name: Elizabeth Nuttall
15. Birthplace: Maryland
16. Informant: Mrs. Isabelle Folger
Address: 1106 West St. Annapolis, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 17, 1945 (month) (day) (year)
Cemetery or crematory: Loraine Cemetery
Location: Baltimore, Md.
18. Funeral director: John W. Taylor & Son
Address: Annapolis, Md.
19. Dec. 17 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 13 1945 at 4.30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7 1945, to Dec 13 1945
and that I last saw him alive on Dec 13 1945

Immediate cause of death	DURATION
Chr. Myocarditis & Arteriosclerosis	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. J. Klavano M.D.
M. D. or other
Address: 31 Southgate Ave. Date signed: 12/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17a)

CERTIFICATE OF DEATH

11875

Reg. Diat. No. 25

1. PLACE OF DEATH:

County Anne Arundel

City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A. A. Co.

City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 907 Victory St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Manderville B. Mc. Elwee

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife Don't Know.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 3. 1872.

8. AGE: Years	Months	Days	If less than one day
73.	11	28	..... hrs. ..... min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual occupation Farmer.

11. Industry or business

FATHER
12. Name Don't Know
13. Birthplace Don't Know

MOTHER
14. Maiden name " " "
15. Birthplace " " "

16. Informant Hazel Mc Elwee.
Address 907 Victory St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 3. 1946 (month) (day) (year)

Cemetery or crematory Glen Haven.

Location Baltimore Highway.

18. Funeral director Martin J. Conroy.

Address 4800 Baltimore Highway

19. January 2 1946 (Date rec'd by registrar) Ida M. Whitlow Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1945, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1945, to Dec 28 1945

and that I last saw him alive on Dec - 28 1945

Immediate cause of death	DURATION
Sepsis	
Due to Decubitus	
Due to Thrombophlebitis	
Other conditions Operated gastric ulcer	

(Include pregnancy within 3 months of death)

Major findings of operations adhesions between duodenum and gall bladder

Date of op. Dec 1, 1945

Autopsy results Gastric ulcer

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Neubauer, M.D.
M. D. or other

Address 914 Patapsco Ave. Date signed 12-31-45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11876

Reg. Dist. No. 56

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 414 Ogston Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MEYERS - ALLEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

6.(b) Name of husband or wife: Beatrice Meyers
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): ------- May 6, 1899

8. AGE: Years	Months	Days	If less than one day
46	---	---	....hrs. ....min.

9. Birthplace: ---------- (Town, county, and state)
10. Usual occupation: ---------
11. Industry or business: ----------

FATHER
12. Name: - - - - -
13. Birthplace - - - - - - -

MOTHER
14. Maiden name: ----------
15. Birthplace --------

16. Informant: Hospital records
Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof December 29, 1945 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Mount Calvert
18. Funeral director: Adlophus Halstead
Address: 918 Druid Hill Avenue

19. 12/27 1945 (Date rec'd by registrar) A. W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 1945, at 9 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 11 1945, to December 25 1945 and that I last saw him alive on December 25 1945.

	DURATION
Immediate cause of death: General Paresis	Known to us since 12/11/45
Due to:	
Due to:	
Other conditions: ---------	

(Include pregnancy within 3 months of death)

Major findings of operations: ----------
Date of op.
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of ----
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ----------
Means of injury ---- Injured at work? ----

23. SIGNATURE: Albert J. Winslow M. D. or other
Address: Crownsville, Maryland Date signed: 12/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

11877

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (162-P)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Morgantown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Unknown.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A.A.
City or town: Morgantown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Rebecca Mulland.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Black.	Single?

6.(b) Name of husband or wife: Louis Mulland
(Prima is husband.) 6.(c) If alive, give age: 70? years

7. Birth date of deceased (mo., day, yr.): ? 1865

8. AGE: Years: 80? Months: Days: If less than one day: hrs. min.

9. Birthplace: Unknown.
(Town, county, and state)

10. Usual occupation: Housekeeping

11. Industry or business

FATHER 12. Name: Unknown.
13. Birthplace

MOTHER 14. Maiden name: Unknown.
15. Birthplace

16. Informant: Louis Mulland
Address: Morgantown

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 15/45 (month) (day) (year)
Cemetery or crematory: Methodist
Location: Morgantown
18. Funeral director: J. B. Johnson
Address: Morgantown

19. 12-13 1945 L. A. Brent
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13 1945, at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__
and that I last saw h__ alive on ____ 19__

Immediate cause of death	DURATION
Heart failure	5
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. H. Pambrook M.D. (acting Medical Examiner) M. D. or other
Address: Glen Burnie Date signed: 12/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

MU 11878

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: CROWNSVILLE MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One year + four months
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? One year + two months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 916 Penneth Place 23
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CLARA MILLER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f.	black	widowed

6.(b) Name of husband or wife:
8.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1892

8. AGE: Years	Months	Days	If less than one day
53			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:

FATHER
12. Name: John Long
13. Birthplace: Md

MOTHER
14. Maiden name: Sarah Parren
15. Birthplace: Md

16. Informant: Hospital records
Address: Crownsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-4-46 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Cemty
Location: Balto. Md.

18. Funeral director: William a. Jackson
Address: 916 Penn. Ave.

19. Jany 6 19 46 E Joyce Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31 1945 at 6 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30 1945, to December 31 1945
and that I last saw h. alive on December 31 1945

	DURATION
Immediate cause of death: General Paresis	Known
Due to:	for a
	since
Due to:	Oct-30-44
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

11879 ★

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Edgewater

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

A.A. County Home.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A.A. Co.

City or town: Magothy

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Friderich Mogal

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 17, 1879

8. AGE: Years	Months	Days	If less than one day
66	7	23	____ hrs. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Grocer.

11. Industry or business

FATHER 12. Name Unknown.

13. Birthplace

MOTHER 14. Maiden name Unknown.

15. Birthplace

16. Informant Mrs Tucker

Address Edgewater P.O.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 10. 1945 (month) (day) (year)

Cemetery or crematory County Home Cem.

Location Edgewater Md

18. Funeral director E. L. Haughey & Son

Address Galesville Md.

19. Dec 10 1945 (Date rec'd by registrar) Edward Coleman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1945, at 3 05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 18 1945, to Dec 9 1945 and that I last saw h.. alive on Dec 7 1945

Immediate cause of death	DURATION
Chr. Myocarditis	2
Due to (b) Decompensation	
Due to Unknown.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. J. Klawans MD M. D. or other

Address 31 South Gate Ave Date signed 12/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

11880

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: West River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: West River
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William Henry Murray

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband: Fannie Chester Murray
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 19 1879

8. AGE: Years	Months	Days	If less than one day
66	1		hrs. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Clephane Murray
13. Birthplace: West River, Md

MOTHER
14. Maiden name: Mary Gibson
15. Birthplace: Baltimore Md

16. Informant: Fannie C. Murray
Address: West River Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 21 1945 (month) (day) (year)
Cemetery or crematory: Christ Church Cem.
Location: West River Md.

18. Funeral director: F. G. Stanfield & Son
Address: Galesville Md

19. 12/20 1945 (Date rec'd by registrar) H. P. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 19 1945 at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 16 1945 to Dec 19 1945 and that I last saw him alive on Dec. 18 1945

Immediate cause of death	DURATION
acute myocardial decompensation	
Due to: Ventricular fibrillation	
Due to: arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D.
M. D. or other
Address: Lothian, Md. Date signed: 12/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11881

Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Anne Arundel Co
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegheny Co
City or town: Pitts Pa
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2812 Neald Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Charles M. Neald

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Roberta Neald
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 8th, 1875

8. AGE: Years	Months	Days	If less than one day
70			..... hrs. ..... min.

9. Birthplace: Pa (Town, county, and state)
10. Usual occupation: Bridge Carpenter
11. Industry or business:
FATHER — 12. Name: John A. Neald
13. Birthplace: Pa
MOTHER — 14. Maiden name: Hetty
15. Birthplace: Pa
16. Informant: Mrs. Chas. Neald
Address: 2111 Penn Rd. Myrtle
17. Buried (Burial, cremation, or removal. Which?) Date thereof: 12 (month) 27 (day) 45 (year)
Cemetery or crematory: Mt. Lebanon
Location: Pittsburg Pa
16. Funeral director: Landsmann Funeral Home
Address: 7401 Bellair Rd

19. Dec. (Date rec'd by registrar) 19 45 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 23 19 45 at 9 50 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 22 19 45 to Dec 23 19 45 and that I last saw h... alive on Dec. 23 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	18 hrs.
Due to: Generalized Arteriosclerosis	20 yrs (?)
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. Bosworth MD (M. D. or other)
Address: Annapolis MD Date signed: 12/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

11882

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergcney Hospital

How long in hospital or institution? 16 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne arundel

City or town: Severn R.F.D. (If outside city or town limits, write RURAL and give nearest town)

Street No.: Chapel Road Nr. Clarks Sta. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George M. Newcomber

3.(b) Social Security Number: 215 07 3250

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Thelma I. Newcomber Nee Gelbert

6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): Feb. 3, 1886

8. AGE:

Years	Months	Days	If less than one day
59	9	3	hrs. min.

9. Birthplace: Petersburg, Va. (Town, county, and state)

10. Usual occupation: Mechanist

11. Industry or business: Ellicott Machine Co

FATHER

12. Name: Unknown Newcomber

13. Birthplace: Virginia

MOTHER

14. Maiden name: Mary meredith

15. Birthplace: Virginia

16. Informant: Mrs. Thelma I. Newcomber

Address: Severn, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 10, 45 (month) (day) (year)

Cemetery or crematory: Church of God Cemetery

Location: Gambrills, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md

19. Dec. 8 1945 (Date rec'd by registrar) MsMcAlfa Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6th December 1945, at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 13/45 19 , to Dec 6th 1945

and that I last saw him alive on December 6 1945

	DURATION
Immediate cause of death: Acute Uraemia	about 2½ days
Due to: Cr. Inter & Renal Nephritis	Several yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Oliver Purvis M. D. or other

Address: Annapolis Md Date signed 12/6/45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (166)

Registered No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Emergency Hospital, Annapolis, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A.
(c) City or town Edgewater
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilson Lee Parker

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	married

6 (b) Name of husband or wife Eliza Parker

6 (c) If alive, give age 20 years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years	Months	Days	If less than one day
27			hr. min.

9. Birthplace Hardwood Anne Arundel Md.
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Washington Parker
13. Birthplace Drury, Md

MOTHER
14. Maiden Name Mary Blake
15. Birthplace Hardwood, Md

16 (a) Informant Washington Parker
(b) Address Hardwood, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/45 (month) (day) (year)

(c) Cemetery or crematory Chews Chapel
Location Owingsville, Md.

18 (a) Funeral director Mrs Ethel Hicks
(b) Address 45 Northwest St. Annapolis

19 (a) 12/27 (Date received by registrar) (b) 45 A.W. Redrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 25 - 1945, at 12:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-25- at Christmas M.
(b) Where did injury occur? Calvert Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearm - revolver

23. Signature Howard J. Lemmon M.D.
Medical Examiner.
Date signed 12-26-45

VS 151

Evidence for change of age is shown on

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 41385 27

FILM No. I 00 JAN 21 1946 State of
FILM No. I 00 JAN 29 1946

1. PLACE OF DEATH:
(a) County Anne Arundel, Maryland
(b) City or town Fort George G. Meade, Md. (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: Regional Hospital, Ft. Geo G. Meade, Md (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days In this community FT. Geo G. Meade, Md. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County _____
(c) City or town Houston (If outside city or town limits, write RURAL)
(d) Street No. 1827 Lyle St. (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) FULL NAME Gilberto Perez
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Male 5. Color or race M 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary Parez 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 13 Oct. ~~1913~~ 1914 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
~~32~~ 31 ~~31~~	2		hr. _____ min.

9. Birthplace Unknown (City, town, or county) (State or foreign country)
10. Usual occupation Railroad
11. Industry or business No

MOTHER FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____
(b) Address _____
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/11/45 (Month) (Day) (Year)
(c) Place; burial or cremation Morales Funeral Home 2901 Canal St. Houston, Texas
18. (a) Signature of funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road
19. (a) _____ (Date received local registrar) (b) Fred D. Jackson Capt MAC (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month Dec. day 11
year 45 hour 0110 minute _____
21. I hereby certify that I attended the deceased from 10 Dec., 1945, to 11 Dec., 1945
that I last saw him alive on 11 Dec, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Infectious Hepatitis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations No operations
Of autopsy Atrophy of Liver Tissue

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature Samuel Rose, Capt MAC (M. D. or other)
Address Regional Hosp., Ft. G.G. Meade, Md. Date signed 20 Dec. 45

8-6017 U. S. GOVERNMENT PRINTING OFFICE 10—13493

COPY SENT TO LOCAL REGISTRAR No. ____ DATE 12/26/45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (134-E)

11886 Registered No. 2x3

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: a.a.
(a) ~~Baltimore City,~~ Maryland
(b) Street address Severn Md
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Severn
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lora E. Potts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife William James Potts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1867

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Joshua Mitchell
13. Birthplace Va

MOTHER
14. Maiden Name Mary Easley
15. Birthplace Va

16 (a) Informant Elijah Potts
(b) Address Severn, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Mark
Location Anne Arundel Co. Md

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) Dec. 26/45 (Date rec'd by registrar) McDealba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1939, to Dec 22 1945, and that I last saw her alive on Dec 20 /45

Immediate cause of death	Duration
Uremic Poisoning (Kidneys)	3-4 days
Due to Chronic Nephritis	
Due to and Endocarditis	Uncertain
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John [illegible] M. D.
Address Glen Burnie Date signed 12/26/45

VS 3

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

11887 28

Reg. Diat. No.

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs. 9 mos, 23 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 13 yrs, 9 mos, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ———
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1204 Pennsylvania Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

3.(a) FULL NAME: Leon Garfield Pratters

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ———
6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): 1907 ?

8. AGE: Years	Months	Days	If less than one day
38 ?	unknown	———	——— hrs. ——— min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: none
11. Industry or business: ———

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Rosa Gassaway
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-17-45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md.
18. Funeral director: Supt Hospital
Address: Crownsville Md

19. 12-17-45 (Date rec'd by registrar) E J Joyce Lord Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8 19 45 at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 15 19 32 to Dec. 8 19 45 and that I last saw him alive on December 8 19 45

Immediate cause of death	DURATION
Chronic Myocarditis	About 3 months
Due to: ———	
Due to: ———	
Other conditions: Imbecile	Known to us since 2/15/32

(Include pregnancy within 3 months of death)

Major findings of operations: ———
Date of op.: ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of: ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ———
Means of injury: ——— Injured at work? ———

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 12/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

CERTIFICATE OF DEATH

11888

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: A. A.

City or town: Friendship

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Friendship

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Susan Selina Pruett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S.

B.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 7 1855

8. AGE: Years	Months	Days	If less than one day
90			..... hrs. ..... min.

9. Birthplace: Md.

(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER

12. Name: Wm T. Pruett

13. Birthplace: Md

MOTHER

14. Maiden name: Ann Saunderland

15. Birthplace: Md

16. Informant: George Lewis

Address: Friendship, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 1/1/46 (month) (day) (year)

Cemetery or crematory: Friendship. "

Location: " "

18. Funeral director: Harry Hellstern

Address: Odessa, Del.

19. 12/31/45 (Date rec'd by registrar) H. P. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Dec 1945, at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 Dec 1945 to 30 Dec 1945 and that I last saw h[illegible] alive on 29 Dec 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Incinde pregnaocy within 3 months of death)

Major fiodiogs of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Harrington, Del. Date signed 31 Dec 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11889

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville, maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County —

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1840 N. Spring Street
(If rural, give LOCATION)

2.(a) If veteran, name war 1st World War

3.(a) FULL NAME Alfred Reason

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Black	married

6.(b) Name of husband or wife Mrs Lavinia Reason

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1889?

8. AGE: Years	Months	Days	If less than one day
58?			....hrs. ....min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual occupation Unknown

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Hospital Records
Address Crownsville, maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 3 1946 (month) (day) (year)

Cemetery or crematory Baltimore National Cem

Location Frederick Road

18. Funeral director 1129 N. Caroline St
Address Mrs Robert Elliott & daughter

19. 1/3 1946 (Date rec'd by registror) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1945 at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 16, 1945 to December 30, 1945 and that I last saw him alive on December 30, 1945

Immediate cause of death	DURATION
General Paresis	Many Yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Crownsville, Md. Date signed 12-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 11883

1. PLACE OF DEATH:
County: Anne Arundel A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Naval Hosp
How long in hospital or institution? 9/16/45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 102 Brewer St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Reynolds, Robert Omer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Rita K Reynolds
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2/29/1888

8. AGE: Years	Months	Days	If less than one day
57	9	15	hrs. min.

9. Birthplace: Atlanta Ga
(Town, county, and state)
10. Usual occupation: CBM USN Ret (mact.
11. Industry or business: US Navy retired
FATHER 12. Name: Robt. F. Reynold
13. Birthplace: Ga.
MOTHER 14. Maiden name: Amy Reynold
15. Birthplace: Ga
16. Informant: Mrs. Robert Reynolds
Address: 102 Brewer St, Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 18th 1945 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington Va
18. Funeral director: John M. Taylor & Son
Address: Annapolis Md.
19. Dec 18 1945 (Date rec'd by registrar) W. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 14 1945, at 0435 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 14 1945 to Dec 14 1945 and that I last saw h. alive on Dec 14 1945

Immediate cause of death	DURATION
Cerebral failure	15 min
Due to: Carcinoma, liver, metastatic	9 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: U.S. Naval Hospital Annapolis Md. Date signed: 12/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 162-6

11890

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County Anne Arundel
City or town Linthicum Heights.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A. A.
City or town Linthicum Heights.
(If outside city or town limits, write RURAL and give nearest town)
Street No. W. Greenwood Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Mattie Agnes Rhinehart.

3.(b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed.

6.(b) Name of husband ~~or wife~~ George H. Rhinehart. 6.(c) If alive, give age Dead. years

7. Birth date of deceased (mo., day, yr.) July-13-1863

8. AGE:

Years	Months	Days	If less than one day
82	4	17	....hrs. ....min.

9. Birthplace New York city N.Y. (Town, county, and state)
10. Usual occupation Housework.
11. Industry or business OWN Home.
12. FATHER Name Ambrose Marton.
13. FATHER Birthplace New York city. N.Y.
14. MOTHER Maiden name Julia Marton
15. MOTHER Birthplace New York city. N.Y.
16. Informant Mrs. Sarah Wartz
Address Linthicum Heights.
17. Burial (Burial, cremation, or removal. Which?) Date thereof DEC 4, 1945 (month) (day) (year)
Cemetery or crematory Friendship Cem.
Location Ft. Meade Road A.A.Co. Md.
18. Funeral director Thomas W. Singleton
Address Glen Burnie Md.
19. Dec 3 1945 (Date rec'd by registrar) McDealbo Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1st 1945, at 12:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1st 1945, to Dec. 1st 1945
and that I last saw h~~er~~ alive on 12/1/45 1945

Immediate cause of death	DURATION
Heart failure	5 days.
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) No
Means of injury Injured at work?

23. SIGNATURE Gustave H. Rambert M.D. M. D. or other
Address Glen Burnie Md. Date signed 12/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

11892 P

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A. A. Co. Md.

City or town North Linthicum
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A. A. Co. Md.

City or town North Linthicum
(If outside city or town limits, write RURAL and give nearest town)

Street No. Charles Road.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William J. Robbins Sr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Lillian M Bennett Robbins

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 1- 1880

8. AGE: Years 65 | Months 0 | Days 26 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business Southern Forge Co.

FATHER 12. Name Richard L. Robbins

FATHER 13. Birthplace Baltimore Md

MOTHER 14. Maiden name Margaret E. Hall

MOTHER 15. Birthplace Baltimore Md

16. Informant Mrs Lillian M. Robbins

Address Charles Rd. N. Linthicum

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-31-1945 (month) (day) (year)

Cemetery or crematory Cathedral

Location Baltimore Md

18. Funeral director Flynn & Fleming

Address 1426 Light St.

19. 12/29 1945 (Date rec'd by registrar) A. W. Hebeler M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1945 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26 1945 to Dec 26 1945

and that I last saw h... alive on Dec 26 1945

Immediate cause of death	DURATION
Pneumonia - Bronchopneumonia	3 days
Due to	
Due to	
Other conditions Hypertension C.V.D.	— —

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Schulz M. D. or other

Address ..... Date signed 12/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (102)

CERTIFICATE OF DEATH

11891 P.

Reg. Diat. No. .....

1. PLACE OF DEATH:
County Anne Arundel.
City or town Patapsco station
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years.
Hospital, Institution, or street address where death occurred:
In neighbor's home.
How long in hospital or Institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A. A.
City or town Patapsco station
(If outside city or town limits, write RURAL and give nearest town)
Street No. East Furnace Road.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Edie Frances Robinson

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Married

6.(b) Name of husband or wife Gordon Robinson
6.(c) If alive, give age 41 years
7. Birth date of deceased (mo., day, yr.) October 5 - 1883

8. AGE: Years	Months	Days	If less than one day
62	2	10	....hrs. ....min.

9. Birthplace Anne Arundel County, Md
(Town, county, and state)
10. Usual occupation Housewife.
11. Industry or business
FATHER 12. Name Amos H. Clark
13. Birthplace Anne Arundel County, Md.
MOTHER 14. Maiden name Boyer
15. Birthplace Anne Arundel Co. Md.
16. Informant Mrs. Gordon Robinson (husband)
Address Patapsco station, Md.
17. Burial Date thereof 12/19/45
(Burial, ~~cremation, or removal. Which?~~) (month) (day) (year)
Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.
19. Funeral director William Cook Inc
Address 1217 St. Paul st
19. 12/17 19 45 .....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1945, at 3.40 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....
and that I last saw h....alive on ....19....

	DURATION
Immediate cause of death Heart failure	Sudden
Due to Stock - due to home surroundings	Sudden.
Due to Hypertension	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of Injury ..... Injured at work?

23. SIGNATURE Gustav H. Baubert M. D. or other
Address Glen Burnie Md. Date signed 12/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

11893

Reg. Diat. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Laurel, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One year, five months

Hospital, Institution, or street address where death occurred:
District Training School

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Laurel-Fort Meade Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Herman Schuman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 10/5/36

8. AGE:

Years	Months	Days	If less than one day
9	2	1	..... hrs. ..... min.

9. Birthplace: Utica, New York
(Town, county, and state)

10. Usual occupation: Inmate

11. Industry or business: None

FATHER
12. Name: Samuel Schuman
13. Birthplace: Poland

MOTHER
14. Maiden name: Ann Davidson
15. Birthplace: Poland

16. Informant: D.T.S. Records

Address: District Tr. School, Laurel, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12 6 45 (month) (day) (year)

Cemetery or crematory

Location: Washington D.C.

18. Funeral director: Damzamsky Funeral Home B. Damzamsky

Address: 3501-14th St NW Wash., D.C.

19. Dec 6 1945 (Date rec'd by registrar) Edna Rastatter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 6, 1945, at 3:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16, 1944, to December 6, 1945 and that I last saw him alive on December 5, 1945

Immediate cause of death	DURATION
Bronchopneumonia	4 days
Due to	
Due to	
Other conditions: Mongolian idiot.	Life

(Include pregnancy within 3 months of death)

Major findings of operations: none ..... Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm M Drummond M.D. M. D. or other

Address: District Training School Date signed 12-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

11894

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
County Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret Smedley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George Smedley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 15, (?)

8. AGE: Years	Months	Days	If less than one day
about 88			..... hrs. ..... min.

9. Birthplace: Annapolis, A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: Home

11. Industry or business

FATHER — 12. Name: Jalen Cassidy
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Elizabeth Mitchell
15. Birthplace: Maryland

16. Informant: Edward R. Cassidy
Address: Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 28, 1945 (month) (day) (year)

Cemetery or crematory: St. Anne's

Location: Annapolis, Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Maryland

19. ..... 19..... (Date rec'd by registrar) Wm. Breuch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 19 45, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 45 to December 25 19 45
and that I last saw h.. alive on Dec 24 19 45

Immediate cause of death	DURATION
(a) Chr. Myocarditis & Decompensation	
Due to: —	
(b) Senility	
Due to:	
(c)	
Other conditions: Senile psychosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. F. Klaware, Md
M. D. or other

Address: 31 Southgate Ave Date signed: 12/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (125-d)

CERTIFICATE OF DEATH

11895

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Conaway – P.O. Isambuckle.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Anne Arundel.
City or town: Camp Parole, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Edward Smith.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Black	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 2/4/44

8. AGE: Years: 1 | Months: 10 | Days: 22 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Johns Hopkins Hosp. – Baltimore
(Town, county, and state)

10. Usual occupation: None.

11. Industry or business

FATHER
12. Name: Unknown. –
13. Birthplace –

MOTHER
14. Maiden name: Marie Smith.
15. Birthplace: Deardonville, Md.

16. Informant: Marie Smith (Mother)
Address: 26 – Cabot St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/29/45 (month) (day) (year)
Cemetery or crematory: Bracewell Hill
Location: West St. Extend.

18. Funeral director: Mrs Chas. D. Hicks
Address: 45 Northmont Annapolis Md.

19. Dec. 28, 19 45 (Date rec'd by registrar) Mae Calla Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25, 1945, at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____
and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Suffocation due to aspiration of food.	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gustave H. Faubert M.D.
Acting Medical Examiner M. D. or other
Address: Glen Burnie Md. Date signed 1/26/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11896

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 61 years
Hospital, Institution, or street address where death occurred: 48 Larkins St. Annapolis Md.
How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 48 Larkins St, Annapolis Md.
(If rural, give LOCATION)
2.(a) If veteran, oame war: None

3. (a) FULL NAME: William Henry Spencer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Colored	Married

6.(b) Name of husband or wife: Mary Spencer
6.(c) If alive, give age: 50 yrs. years

7. Birth date of deceased (mo., day, yr.): October 16 1884

8. AGE: Years	Months	Days	If less than one day
61	2	10	....hrs. ....min.

9. Birthplace: Davidsonville Md. A. A. Co. (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: None
FATHER 12. Name: William Henry Spencer Sr.
FATHER 13. Birthplace: Davidsonville Md.
MOTHER 14. Maiden name: Martha Davis
MOTHER 15. Birthplace: Davidsonville Md.
16. Informant: Mary Spencer
Address: 48 Larkins St. Annapolis Md.
17. burial (Burial, cremation, or removal. Which?) Date thereof 12/30/45 (month) (day) (year)
Cemetery or crematory: Brew Hill Cemetery
Location: West St. Extd. Annapolis Md.
18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.
19. Dec. 28 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 26 1945, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/2 1944, to 12/26 1945
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Carcinoma of Stomach	1 yr
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: J. H. Johnson M. D. M. D. or other
Address: 45 Northwest Street Date signed 12/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11897

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 81 years
Hospital, Institution, or street address where death occurred: U. S. Naual Hospital Annapolis Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 64 Washington St. Annapolis Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American

3.(a) FULL NAME: William Taylor

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Widower

6.(b) Name of husband or wife: Henreitta Taylor
6.(c) If alive, give age: (blank) years

7. Birth date of deceased (mo., day, yr.): December 19, 1864

8. AGE: Years 81 | Months | Days 12 | If less than one day: hrs. min.

9. Birthplace: Washington D. C.
(Town, county, and state)

10. Usual occupation: fireman in U. S. Navy Academy

11. Industry or business: None

FATHER
12. Name: Wesley Taylor
13. Birthplace: West River

MOTHER
14. Maiden name: Harriet Howard
15. Birthplace: West River Md.

16. Informant: Taylor
Address: 64 Larkins St. Annapolis Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 1/4/46 (month) (day) (year)
Cemetery or crematory: Brew Hill Cemetery
Location: West St. Extd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Jan. 2 1946
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-31 1945 at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-29 1945 to 12-31 1945 and that I last saw h. alive on 12-30 1945

Immediate cause of death	DURATION
Rupture of Aneurysm aorta	1 min.
Due to Dissecting aneurysm aorta	10 yrs.
Due to Arteria sclerosis generalized.	20 yrs.
Other conditions Congestive Heart failure.	3 days.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Rupture aortic aneurysm.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John J. Murdock Jr. M. D. or other
Address: U.S. Naval Hosp. Annapolis Md. Date signed 12-31-45.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

11898

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 12 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 month, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Jessups
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. #1
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: THOMPSON - MARY FRANCES (Thornton)

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years	Months	Days	If less than one day
66	unknown		----- hrs. ----- min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: ---

FATHER
12. Name: John Thornton
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Nancy Hill
15. Birthplace: West Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec. 16, 1945 (month) (day) (year)
Cemetery or crematory:
Location: Charlestown, West Virginia
18. Funeral director: Mrs. Geo. Hemsley
Address: 578 W. Biddle St., Baltimore, Md.

19. 12/14, 1945 (Date rec'd by registrar) E.T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11, 1945, at 8:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 29, 1945, to Dec. 11, 1945 and that I last saw her alive on December 11, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to: ---	
Due to: ---	
Other conditions: Senile Psychosis	Known to us since 10/29/45

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Herbert V. Drinteroe, M. D. or other
Address: Crownsville, Maryland Date signed: 12/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11899

Reg. Dist. No. 2

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Martha Ellen Tongue

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): NOV. 6. 1945

8. AGE: Years	Months	Days	If less than one day
Twelve	1	21	hrs. min.

9. Birthplace: Cumberland (Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER — 12. Name: Clinton Tongue

13. Birthplace: Cumberland Md

MOTHER — 14. Maiden name: Maude Cornelia Johnson

15. Birthplace: Cumberland

16. Informant: Martha Johnson

Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 28 45 (month) (day) (year)

Cemetery or crematory: Man'l Star Cem.

Location: Vault Point Md

18. Funeral director: D. A. Headley & Son

Address: Galesville Md.

19. 12/29 45 (Date rec'd by registrar) H. R. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 27 1945 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 27 1940 to Dec 27 1940

and that I last saw h[illegible] alive on Dec 27 1945

Immediate cause of death	DURATION
Lobar pneumonia	1wk (?)
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: S. Brownell. MD M. D. or other

Address: Annapolis Md Date signed 12/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-6)

CERTIFICATE OF DEATH

11990

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 96 years
Hospital, institution, or street address where death occurred:
34 Cathedreal St. Annapolis Md.
How long in hospital or institution? ———

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 34 Cathedreal St. Annapolis Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: James Tyler

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife: Julia Tyler
6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): October 1849

8. AGE: Years	Months	Days	If less than one day
96	2		... hrs. ... min.

9. Birthplace: SouthRiver A. A. Co. Md. (Town, county, and state)
10. Usual occupation: Cook in U. S. Naval Academy
11. Industry or business: None

FATHER
12. Name: Stephen Tyler
13. Birthplace: SouthRiver A. A. Co. Md.

MOTHER
14. Maiden name: Rachel Jennings
15. Birthplace: South River A. A. Co Md.

16. Informant: Mrs Isabelle Jennings
Address: 916 Smithville , Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 (month) /26 (day) /45 (year)
Cemetery or crematory: Brew Hill Cemetery
Location: West St. Extd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Dec. 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/22 1945 at 1 50 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12/20 1945, to 12/22 1945
and that I last saw him alive on 12/21 1945

Immediate cause of death	DURATION
Cardiac fracture	2 hr
Due to: Mitral Insufficiency	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: T. S. Johnson M.D. M. D. or other
Address: 40 Northwest Street Date signed 12/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

11901

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Gambrills R F D
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrills R F D
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Nellie Virginia Warfield

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
8.(c) If ailve, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct 31 - 45

8. AGE: Years | Months: 1 | Days: 11 | If less than one day: hrs. min.

9. Birthplace: Gambrills Md Anne Arundel Co
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: William Marion Warfield
13. Birthplace: Washington DC

MOTHER
14. Maiden name: Elsie E Wilson
15. Birthplace: A A Co Md

16. Informant: Mrs Wm Warfield
Address: Gambrills Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 13 45 (month) (day) (year)
Cemetery or crematory: St Lincoln
Location: A A Co. Md

18. Funeral director: Clarence Forrer
Address: Millersville Md

19. 1-14-1946 (Date rec'd by registrar) E F Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 11 19 45 at 9A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 4 19 45 to Dec 10 19 45
and that I last saw h... alive on Dec 10 19 45

	DURATION
Immediate cause of death: Pneumonia Bronchial	5 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: O H Mac Neman M D
M. D. or other
Address: Millersville Date signed 12-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

11902

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 20 Cathedral St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rose May White

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Charles A. White
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 12 1866

8. AGE: Years	Months	Days	If less than one day
79	7	17	..... hrs. ..... min.

9. Birthplace Annapolis Md.
(Town, county, and state)
10. Usual occupation Retired Employee
11. Industry or business State of Maryland
FATHER 12. Name Unknown
13. Birthplace Unknown
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant Arthur R. White
Address Chesapeake Ave Eastport Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 20 1945 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md.
18. Funeral director John M. Taylor & Son
Address Annapolis Md.
19. Dec. 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1945, at 4 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1945 to Dec 17 1945
and that I last saw her alive on Dec 17 1945

	DURATION
Immediate cause of death: Myocardial Insufficiency	
Due to: Myocardial Degeneration	Unknown
Due to:	
Due to:	
Other conditions: Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE George C. Buell M. D. or other
Address Annapolis Md Date signed 12-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

11903

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 27 Southgate Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No. 27 Southgate Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Grace Lingee Willcox

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 23, 1859

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
86	5	18		

9. Birthplace: Annapolis - A.A. Co. - Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business: —

FATHER — 12. Name: Wm Henry Willcox

13. Birthplace: Connecticut

MOTHER — 14. Maiden name: Katherine Wells

15. Birthplace: Annapolis, Md.

16. Informant: Miss Catherine Willcox

Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 13, 1945 (month) (day) (year)

Cemetery or crematory: St. Annes Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Md.

19. 12-13 1945 (Date rec'd by registrar) h. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 11 1945, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944 to Dec 11 1945 and that I last saw h[illegible] alive on Dec 10 1945

Immediate cause of death	DURATION
Myocarditis & Myocardial Insufficiency Chr.	Several years
Due to	
Due to	
Other conditions Cerebral Sclerosis	Autumn

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George C. Basil M. D. or other

Address: Annapolis Md. Date signed 12-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

11904

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: WILSON - JENNIE

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: John Wilson, Pocomoke, Md.
6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1882

8. AGE: Years: 63 | Months: unknown | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ------

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-10-45 (month) (day) (year)
Cemetery or crematory: Crownsville, Hospital
Location: A. A. Co.

18. Funeral director: Supt Hospital
Address: Crownsville Md

19. Dec 10 1945 (Date rec'd by registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8 19 45, at 5:20 AM

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from November 10 19 45, to Dec. 8 19 45
and that I last saw her alive on December 8 19 45

	DURATION
Immediate cause of death: Chronic Myocarditis	Known to us since 11/10/45
Due to: ----------	
Due to: ----------	
Other conditions: Senile Psychosis	Known to us since 11/10/45

(Include pregnancy within 3 months of death)

Major findings of operations: ---------- Date of op.: --------

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: ----------
Where did injury occur? ------ ------ ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? ----------

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed 12/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

CERTIFICATE OF DEATH

11905

Reg. Dist. No. 26

1. PLACE OF DEATH:
County Anne Arundel
City or town Deale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Deale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war none

3.(a) FULL NAME Richard James Wooden

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1 1892

8. AGE:	Years	Months	Days	If less than one day
	53	6	14	hrs. min.

9. Birthplace Trappe Md.
(Town, county, and state)
10. Usual occupation Farm hand
11. Industry or business Farmer
FATHER 12. Name Ned Wooden
13. Birthplace Md
MOTHER 14. Maiden name Eliza Wooden
15. Birthplace Md
16. Informant Milton Carter
Address Mutual Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/18/45 (month) (day) (year)
Cemetery or crematory Union Chapel
Location McKendree Md.
18. Funeral director T. O. Hardesty & Son
Address Baltimore Md.
19. Dec 17 1945 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1945 at about 6:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post-mortem Examination to Dec. 16, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	Sudden
Due to Cerebral Sclerosis	Unknown
Due to Arterial Hypertension	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Caffey M.D. Deputy Medical Examiner
M. D. or other
Address Annapolis, Md. Date signed 12/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-01)

CERTIFICATE OF DEATH

11906

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 115 Chesapeake Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 115 Chesapeake Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Teresa Zemaitis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Anthony Zemaitis
(c) If dead, give age ... years

7. Birth date of deceased (mo., day, yr.): May 28th 1865

8. AGE: Years	Months	Days	If less than one day
80	6	6	... hrs. ... min.

9. Birthplace: Lithuania (Town, county, and state)
10. Usual occupation: none
11. Industry or business
FATHER 12. Name: Michael Dawnis
13. Birthplace: Lithuania
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Mrs Michael Dychus
Address: 115 Chesapeake Ave Eastport
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 6 1945 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis, Md.
18. Funeral director: John M. Taylor & Son
Address: Annapolis Md.
19. Dec 6 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-4 1945, at 3:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 20 1945, to Dec 4 1945, and that I last saw h.e.r. alive on 12-4 1945

Immediate cause of death: Hypertensive Cardio Vascular Renal disease — DURATION: 15 yrs.
Due to:
Due to:
Other conditions: Pulmonary Edema
(Include pregnancy within 3 months of death)
Major findings of operations: ... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Eastport, Md. Date signed: 12-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15